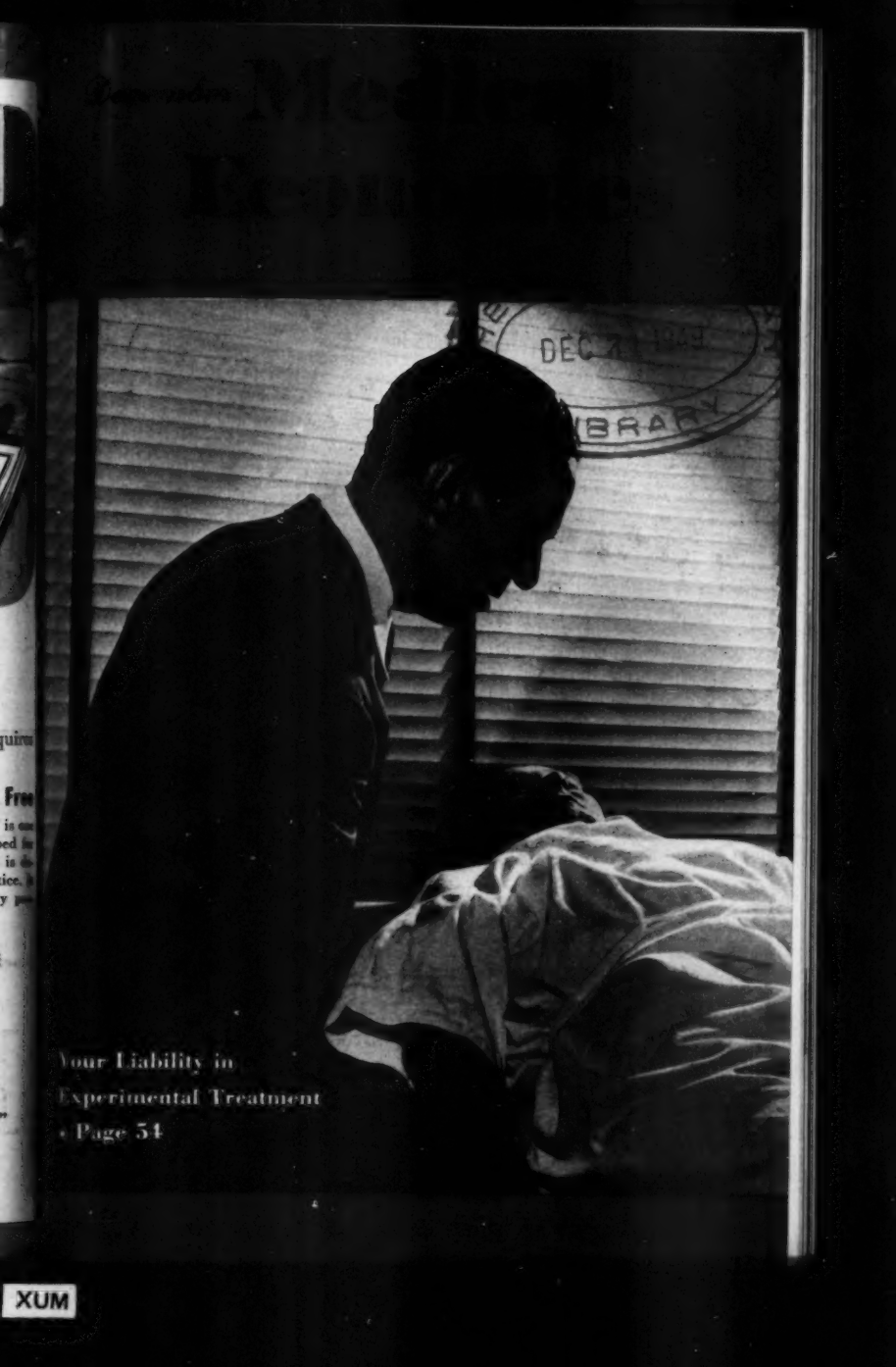
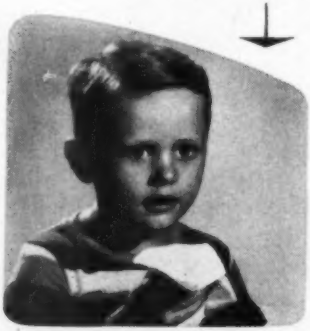


Your Liability in
Experimental Treatment
• Page 54

Gives the cough relief your patient wants...

Leaves the cough reflex he needs



In the average case, it's usually possible to control the patient's cough—but often it's a real problem to do it without impairing the cough reflex he needs to keep bronchioles and throat passages clear. That's where you'll find pleasant-tasting Mercodol unique!

For Mercodol contains the cough-controlling narcotic[1] that gives better antitussive action than codeine or heroin, yet keeps beneficial cough reflex . . . a superior bronchodilator[2] to relax plugged bronchioles . . . an effective expectorant[3] to liquefy secretions. And you'll find Mercodol notably free from nausea, constipation, retention of sputum, and cardiovascular and nervous stimulation.

MERCODOL®

AN EXEMPT NARCOTIC

The antitussive syrup that controls cough—keeps the cough reflex

Merrell

CINCINNATI • U. S. A.

Each 30 c.c. contains:
[1]Mercodinone* 10.0 mg.
[2]Nethamine® 0.1 gm.
[3]Sodium Citrate 1.2 gm.
*Trademark.

Medical Economics

• • • *December 1949* • • •

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Check Menstrual Flooding

Considerable irregularity in flow may mark the onset of menstruation at puberty. Menorrhagia, with or without dysmenorrhea, may be most troublesome. In these cases, the excessive bleeding is usually purely functional in character—an organic lesion may be conspicuously absent. This excessive functional bleeding may occur later in life, too.

Anti-Menorrhagic Factor Armour

has proven effective in checking such functional hemorrhage—and appears to be quite free from side effects. Best time to start therapy is about two weeks prior to expected onset of menstruation.

Available in soft gelatin capsules (glanules) in boxes of 25, 50 and 100.

Dosage:

Two or three glanules three times daily. For very severe cases patient may be confined to bed during bleeding and dosage upped as high as 8 glanules t.i.d.

Have confidence in the preparation you prescribe—specify "Armour"

ARMOUR Laboratories

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

Memo from the Publisher

● "To be completely successful," the saying goes, "a specialized magazine has to reach and be read by every person for whom it's intended."

That's a tall order. Probably no publication will ever fill it 100 per cent. But you may be interested to hear how one of them tries.

Take the matter of reaching all interested parties. In MEDICAL ECONOMICS' case, this is the chief concern of half a dozen full-time employes. Theirs is the task of keeping M.E.'s circulation file up to date, of seeing that each issue gets to the private physicians it's written for. This often requires the talents of a Hawkshaw and the patience of Job.

Some months ago, for example, our circulation department made a telephone check of every physician in New York City. A Manhattan hotel room was hired, eight trunk lines installed, and eight telephone operators put to work. The job took nearly two weeks, involved 14,000 calls. The errors discovered in M.E.'s mailing list amounted to 3 per cent—and most of these would have been caught automatically within a few months.

Recent phone checks have also been made in Philadelphia, Buffalo, and Trenton. Recent mail checks have been conducted in

Pittsburgh and in the State of Virginia. Similar checks are going on all the time.

Our circulation sleuths have three other ways of keeping track of you. For one thing, many of you tell us promptly about your changes of address (the form appears on page 89 of this issue). For another thing, the postoffice lets us know when (but not always where) you move. The list is also kept up to date with the help of the AMA directory service.

If you've thought of physicians as being a fairly settled lot, our circulation people would hasten to take issue with you. In the first six months of this year, 32,436 medical men shifted their office locations, entered private practice for the first time, died, or reached retirement age. All of which meant that the addresses on M.E.'s list had to be changed at the rate of almost 50 per cent a year—the vast majority of the changes stemming from relocations.

Of the 202,516 M.D.'s in the country, some 63,000 are not in private practice or are over 65. MEDICAL ECONOMICS reaches nearly all the rest. The list now includes 139,198 names—which, incidentally, makes M.E. the most widely circulated publication among doctors.

Reaching the interested parties is, of course, only a starter. They still have to be induced to read the magazine. The story of M.E.'s readership (which has measured as high as 95 per cent) we'll save for a later month. —LANSING CHAPMAN

EFFICIENCY EXPERT... dietary dub!

Bolt the hamburger, gulp the coffee, and another meal is efficiently handled. Too bad his body machinery breaks down under this system, and he joins the ranks of those half-sick, half-well patients who show symptoms of avitaminosis B. • For such patients, you probably prescribe a sensible diet augmented with a potent vitamin B preparation. May we suggest SUR-BEX? It has the well rounded formula you desire for either preventive or corrective use. And it is made in triple-coated tablets which are palatable and easy to take. Open the bottle and notice the pleasant fragrance. There's no trace of the odor of liver, yeast or vitamin B concentrates. • To the potent SUR-BEX formula, SUR-BEX WITH VITAMIN C adds 150 mg. ascorbic acid. Both products available in bottles of 100, 500, 1000.

ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

Each triple-coated SUR-BEX Tablet contains:

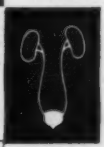
Thiamine hydrochloride	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine hydrochloride	1 mg.
Pantothenic acid (as calcium pantothenate)	10 mg.
Liver fraction (boiling water extract)	0.3 Gm. (5 grs.)
Brewer's yeast dried	0.15 Gm. (2½ grs.)

SUR-BEX®

(ABBOTT'S VITAMIN B COMPLEX TABLETS)

5 good reasons

There are five good reasons why SULAMYD* (Sulfacetimide-Schering) is the preferred sulfonamide in the treatment of pyelitis, pyelonephritis, cystitis and other infections of the urinary tract.



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1. ***Unusual efficacy:*** In *B. coli* infections of the urinary tract, recovery or improvement with SULAMYD is unusually high, ranging from 93 to 98% of cases.[1,2]

2. ***High urinary levels:*** Due to SULAMYD's rapid clearance from the blood and easy excretion by the kidneys, high urinary concentrations are obtained in the presence of low blood levels.[3]

3. ***Excellent renal tolerance:*** Crystalluria is rare and anuria has never been reported following SULAMYD therapy. This enviable record is due, in large measure, to SULAMYD's remarkable solubility (946 mg. per 100 cc.), approximately 80 times that of sulfadiazine.[3]

4. ***Systemically well tolerated:*** Side effects are minimal and uncommon. SULAMYD may, therefore, be administered with greater security to infants, children and pregnant women.[1,4]

5. ***Alkalinization is unnecessary,*** since SULAMYD is quite soluble in both acid and alkaline urine.

PACKAGING: SULAMYD, sulfacetimide, tablets of 0.5 Gm., in bottles of 100 and 1,000 tablets; and bottles of 5.0 Gm. powder, for laboratory determinations upon blood and urine.

BIBLIOGRAPHY: (1) Wolchir, F., and Barnes, R.W.: J.A.M.A. 117:2123, 1941. (2) Alyea, E.P., and Parrish, A.A.: South. M.J. 40:670, 1947. (3) Lehr, D.: J. Urol. 54:37, 1945. (4) Preston, R.J., and Kennedy, J.F.: J. Urol. 47:31, 1942.

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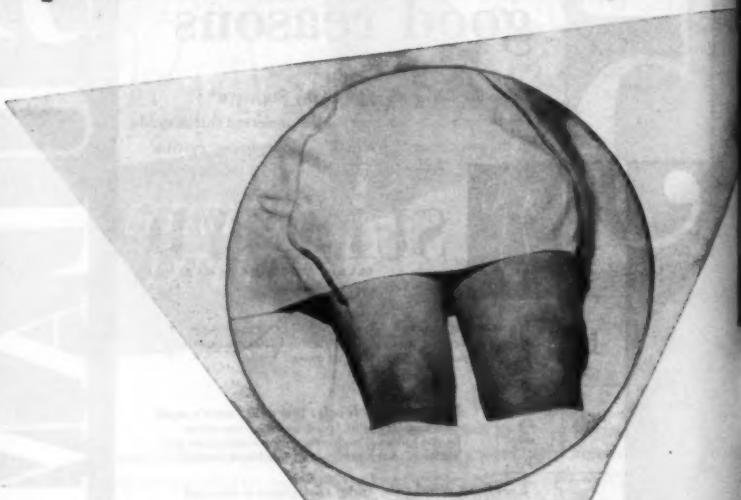


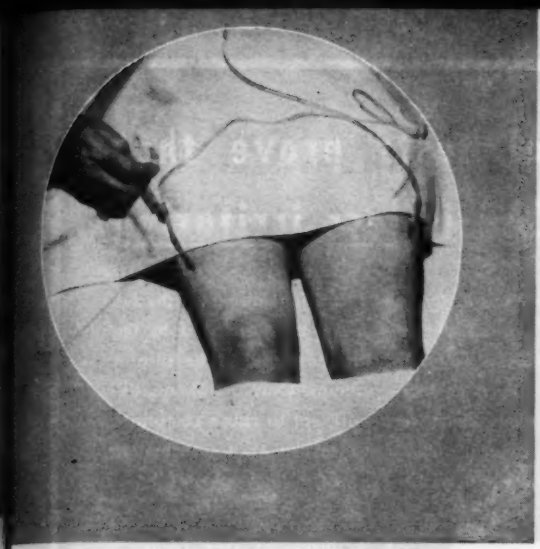
Completion of hypodermoclysis. Right leg: comfort, safety, rapid absorption. Left leg: swelling, pain, slow absorption.

ALIDASE*

Searle (highly purified hyaluronidase) injected through the hypodermoclysis tubing makes it possible to administer subcutaneous fluids with the speed, comfort and safety of the intravenous route.

Clinical studies have demonstrated that Alidase markedly increases the rate of absorption of saline, plasma, glucose, Hartmann's or Ringer's solution. The absorption of penicillin, streptomycin, procaine and adrenalin is also facilitated.

The swelling, induration and discomfort which ordinarily accompany hypodermoclysis are negligible when Alidase is employed.



Start of hypodermoclysis. Alidase injected in right leg. No Alidase used in left leg.

USUAL DOSE: One ampul per 500 to 1,000 cc. of hypodermoclysis fluid.

ADMINISTRATION: It may be: (a) injected through the wall of the rubber tube near the hypodermoclysis needle or (b) dissolved directly in the solution (when the amount of fluid to be injected is small).

REFERENCES:

1. Meyer, K.: Physiol. Rev. 27:335 (July) 1947.
2. Sannella, L. S.: Yale J. Biol. & Med. 12:433 (March) 1940.
3. Seifter, J., and Christian, J. J.: Presented at The New York Academy of Science in the Section of Biology, (Dec. 4) 1948.
4. Schwartzman, J.; Henderson, A. T., and King, W. E.: J. Pediat. 33:367 (Sept.) 1948.
5. Schwartzman, J.: J. Pediat. 34:559 (May) 1949.

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Clinical tests prove that PRO-CAP is less irritating

"141 patients, including the 130 developing adhesive irritations of various degrees, were then exposed to the adhesive tape containing the fatty acid salts. The plaster was used 970 times on these patients. Only 5 patients developed irritations which were sufficient to cause complaint. The irritation even in those instances was not sufficient to warrant discontinuation of the use of this new plaster."

—R. E. Humphries: New Factors in Adhesive Formulas Which Lessen Irritation. J. Investigative Derm. 9:219-220 (Nov.) 1947

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Seamless PRO-CAP is a superior quality Adhesive Plaster containing zinc propionate and zinc caprylate—two medically-proved ingredients. PRO-CAP provides these *three* important advantages, *at no increase in price!*

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RESULT: More comfort for your patient . . . Less interference with your treatment . . . We invite you to discover PRO-CAP's outstanding qualities in your own practice. Write for illustrated brochure and reprints of medical reports.

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Panorama

Five-year battle by Australian M.D.'s to repeal law giving limited list of medicines free to public has ended in victory. Highest Australian court recently declared law invalid . . . New York State health authorities now sponsoring a program to teach practicing physicians how to handle atomic-blast patients . . . When a copperhead snake sank its fangs into his leg, Charles Johnston of Wheeling, W. Va., kept calmly on with his work. He didn't need a doctor, Johnston explained: The leg was artificial.

Overworked pediatricians may find it hard to believe, but nearly half of America's 37 million families are childless . . . Weekly radio program, "Doctor's Orders," featuring health talks by practicing physicians, has been promoted from local to national networks . . . Dr. Rudolph P. Zaletel of Chicago is suing Illinois Bell Telephone for $300,000. He charges the company failed to transfer calls to an associate while he was out of town, thus gave patients the impression he had quit practice . . . Big advantage of Gallinger Hospital's new home-care plan for indigents, according to Dr. Joseph F. Fazekas, chief medical officer of the District of Columbia institution: "It will teach young doctors to fight sickness in its own environment, the family home."

British Health Minister, Aneurin Bevan, will go to India and give Asiatics his Rx for their health problems . . . More than 30 per cent of home accidents occur in kitchen or dining room; Metropolitan Life Insurance Company calls on physicians to help warn the public about these domestic dangers . . . Diphtheria, meningitis, and pneumonia are on the increase among elderly persons, reports Dr. Henry D. Brainerd

FOR ANY DIET . . . AT ANY AGE . . . RENNET-CUSTARDS

Psychologic Anorexia

Inviting, rather than forcing, rebellious or flagging appetites, delicious rennet desserts (easily made from "Junket" Brand Rennet Powder or Tablets) prove most helpful. Retaining all of milk's nutritive values, yet possessing varied flavor and color appeal—these simple, attractive, eggless custards are almost invariably consumed without bribe or persuasion. Besides pleasantly disguising uncooked milk, rennet-custards produce soft, finely flocculent, easily digested curds in the stomach. More and more physicians are thus finding rennet desserts a valuable means of counteracting the "finicky behavior" often attached to milk.

Just a reminder, Doctor! Mothers will appreciate your inclusion of rennet desserts in your diet recommendations.

They impart delicious variety, taste-tempting attractiveness and ease of preparation to milk desserts.

"JUNKET" BRAND FOODS
DIVISION
Chr. Hansen's Laboratory, Inc.
LITTLE FALLS, N. Y.
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Make delicious rennet desserts with either:

"Junket" Rennet Powder — sweetened, in six flavors (vanilla, chocolate, lemon, orange, raspberry, maple).

"Junket" Rennet Tablets — unsweetened, unflavored (particularly for very young infants and diabetics).

"JUNKET" is the trade-mark of Chr. Hansen's Laboratory, Inc. for its rennet and other food products.

of the University of California Medical School . . . Malpractice suit for a whopping $768,096 has been brought against Oklahoma physician . . . When he heard brakes screech outside his Brooklyn office, Dr. S. L. Shandalow rushed to aid child struck by car. Not until he got the dying boy inside office did he discover it was his son.

Members of the Wood River (Ill.) Medical Society refused to accept payment for emergency services rendered during recent tornado. Doctors set up emergency hospital, worked on 24-hour duty, provided medications free . . . American Foundation for Homeopathy plans to construct national headquarters, including clinic and post-graduate school, in District of Columbia . . . Doll hospital in Florida has a licensed M.D. as head surgeon. His wife started the project; she got the doctor to take it up as a hobby.

Sponsors of Mrs. America Beauty Contest have ruled it O.K. for contestants to wear falsies; the devices are still banned in the Miss America contest . . . Man in Castleton, N.Y., has filed $115,000 negligence suit against state health department, charging plasma injections given his daughter contained jaundice germs that caused her death . . . Gorillas at the Bronx Zoo are kept behind glass—to keep them from catching sightseers' sniffles and sneezes . . . In a breathless "Amendment to Announcement No. 173 (Unassembled) of 1949 (Amends Issue No. 28 of AN 2279)," the Civil Service Commission announced on Sept. 7 that the maximum salary step for a "Medical Officer (Psychiatric Resident)" would be $4,150 a year, rather than $4,100. The extent of the rush for this 99c-a-week "raise" has not been disclosed.

International Neurological Congress, meeting in Paris, called for recognition of neurology as an independent specialty, claimed "all medical therapies dealing with the nervous system" as the neurologist's province . . . Los Angeles housewife who broke out in a rash every time her spouse came near her has been granted an annulment; doctors diagnosed her trouble as neurodermatitis.

A Pharmaceutical Triumph in

In **Vi terra**, J. B. Roerig and Company offer you for the first time a more complete, balanced formula for the management of multi-vitamin deficiencies. **Vi terra** is the result of years of intensive research, together with months of pharmaceutical manufacturing research. Indicated wherever you would normally use multi-vitamins.

9 vitamins and 12 minerals } all in 1 capsule

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in Multi-Vitamin Therapy

Multi-vitamins are not alone the complete answer to protective nutrition. More and more, the mineral elements are being recognized as "spark plugs"—playing an all-important, if still unmeasured part in building and restoring body health. The catalytic-synergistic action of the minerals with the vitamins makes the difference in speeding up enzymatic processes on which the body is dependent for its functions.

Vi terra contains all the vitamins known to be essential to human nutrition and, in addition, 12 minerals designed to act as catalysts in improved vitamin metabolism. Advance clinical reports indicate that when proper minerals are supplied with the necessary vitamins, the powerful activity of the enzymes present in the body is stimulated and increased.

With **Vi terra,** the physician or surgeon can anticipate more rapid and potent effects than can be obtained with less complete formulations.

ALL IN ONE CAPSULE

VITAMINS		MINERALS	
Vitamin A *(Refined Fish Liver Oil)*	5,000 USP Units	Cobalt *(Cobaltous Sulf. .7 H_2O)*	0.1 mg.
Vitamin D *(Irradiated Ergosterol)*	500 USP Units	Copper *(Cupric Sulfate)*	1 mg.
Vitamin B_1 *(Thiamine Hydrochloride)*	3 mg.	Boron *(Sodium Metaborate)*	0.2 mg.
Vitamin B_2 *(Riboflavin)*	3 mg.	Iron *(Ferrous Sulfate)*	10 mg.
Vitamin B_6 *(Pyridoxine Hydrochloride)*	0.5 mg.	Iodine *(Potassium Iodide)*	0.15 mg.
Niacinamide	15 mg.	Calcium *(DiCalcium Phosphate)*	213 mg.
Vitamin C *(Ascorbic Acid)*	50 mg.	Manganese *(Manganous Sulf.)*	1 mg.
Calcium Pantothenate *(Dextro)*	5 mg.	Magnesium *(Magnesium Sulf.)*	6 mg.
Mixed Tocopherols Type IV	5 mg.	Molybdenum *(Sodium Molybdate)*	0.2 mg.
		Phosphorus *(DiCalcium Phosphate)*	165 mg.
		Potassium *(Potassium Sulf.)*	5 mg.
		Zinc *(Zinc Sulfate)*	1.2 mg.

DOSAGE: Due to the catalytic-synergistic action of certain minerals with vitamins in vivo, it is suggested that one **Vi terra** capsule a day will serve adequately for supplementary nutrition. For quicker results three or more **Vi terra** capsules daily may be prescribed. Supplied in bottles of 100 capsules. You are invited to send for a clinical trial supply.

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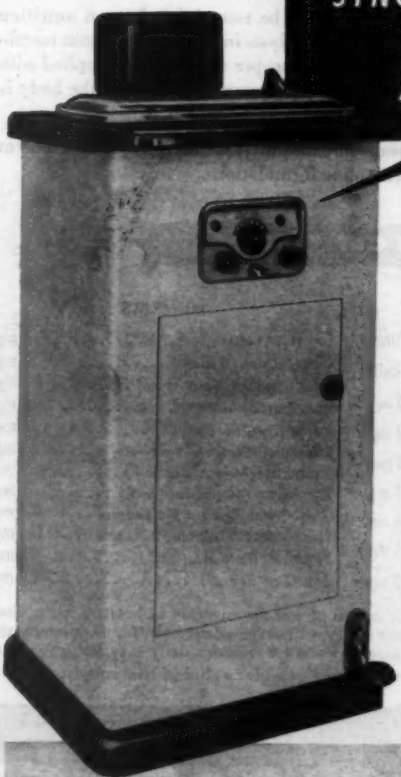
You Can Forget About Sterilization

Ritter's SYNCHRONOUS TIMER Sterilizes Automatically!



●Now you can concentrate ... your important income-pro... ing work. This amazing ... chronous timer makes ... Ritter sterilizer a faithful, ... pletely automatic servant. ... timer operates *only* when ... reaches the boiling point. ... know positively that your in... ments have been fully steri... for the required time. ... bother with sterilization de... Let a new Ritter DeLuxe Hy... matic Sterilizer take care of ... for you, *automatically.*

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Model "E-3" 16" New Timer Assures Complete Sterilization

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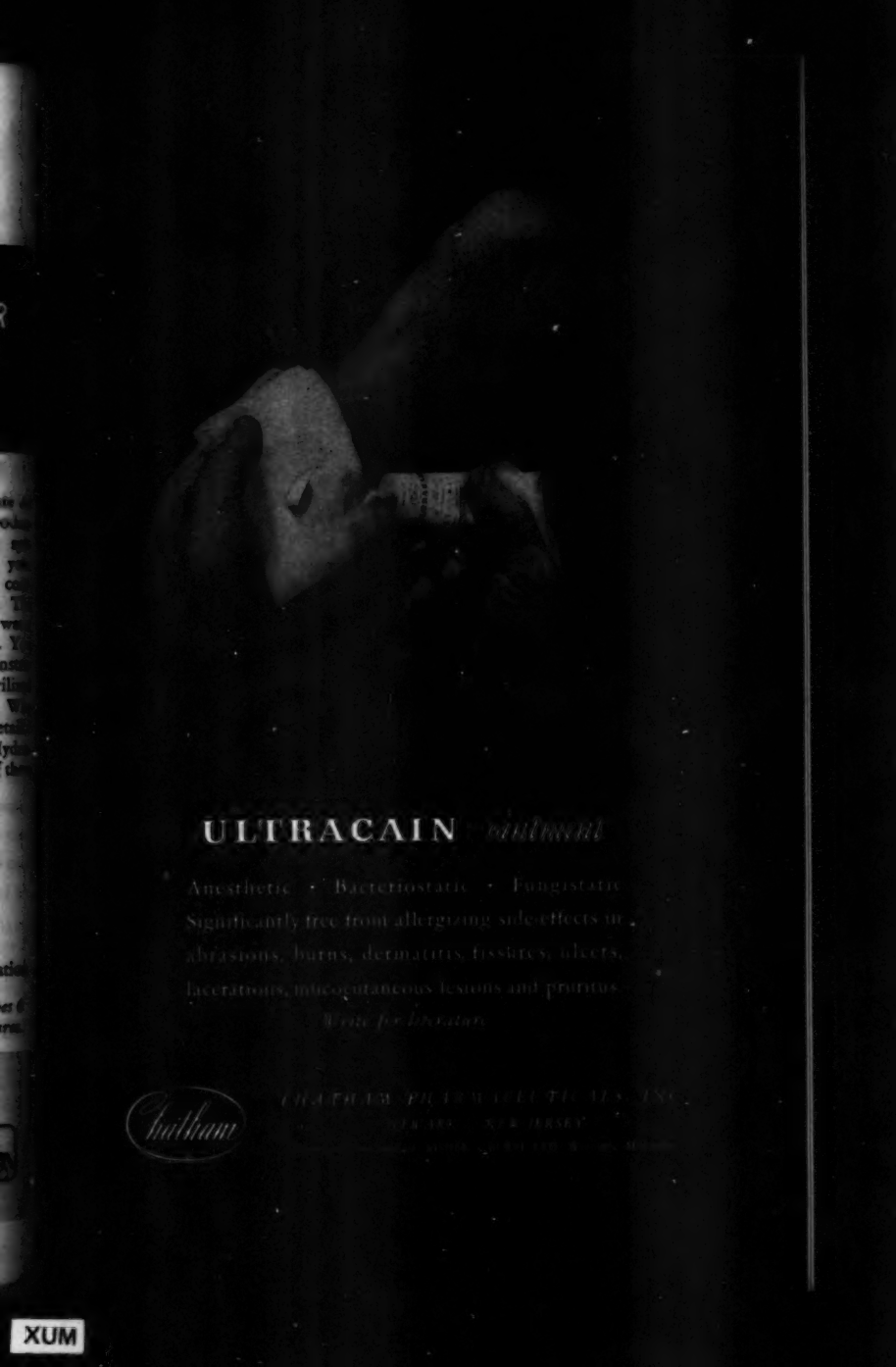
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Anesthetic · Bacteriostatic · Fungistatic
Significantly free from allergizing side-effects in
abrasions, burns, dermatitis, fissures, ulcers,
lacerations, mucocutaneous lesions and pruritus
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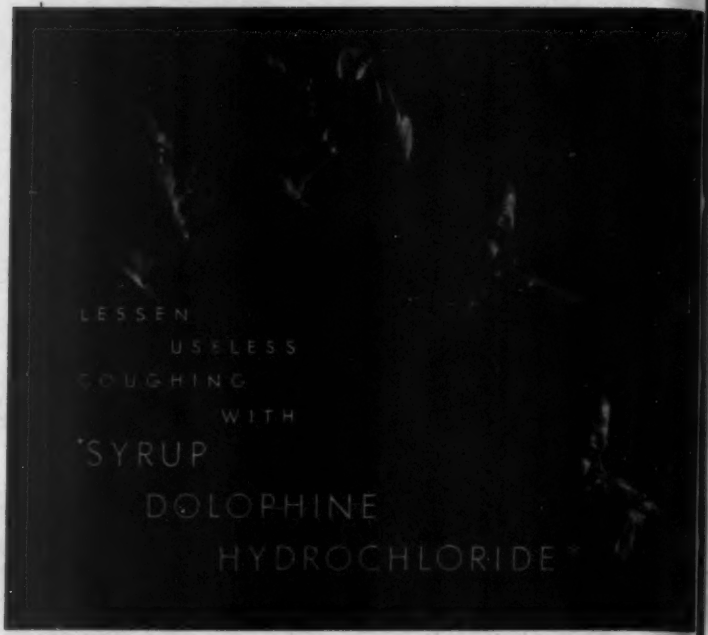

*(Methadon Hydrochloride, Lilly)

Cough, especially when unproductive and irritating, interferes with rest and sleep and may be painful. 'Dolophine Hydrochloride' quiets an overactive cough reflex without altering respiratory rate or air volume. Compared with opium derivatives, it is more effective in smaller doses and its action lasts over a longer period of time.

This palatable cherry-flavored syrup fully deserves the physician's preference.

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Literature on Syrup 'Dolophine Hydrochloride' is available from your Lilly medical service representative or will be forwarded upon request.

• Narcotic order required.

Speaking Frankly

Forecast

I have consistently opposed communistic medicine. But, mark my word, it is going to come. The average layman is like a man sleeping on a plank: He keeps turning over to find a softer place. The high and increasing cost of sickness appalls him and puts him in a frame of mind to grasp anything that promises a lessening of the burden.

Doctors today charge too much. When I began practicing sixty years ago, I charged $1 for an office consultation and medicine. After some years, I advanced my charge to $1.50. I have maintained it at this figure ever since. At 83, I am still practicing and making a comfortable living—and even salting away a few bonds for my old age.

R. B. Furman, M.D.
Sumter, S.C.

Dissent

In your September issue appears an article entitled "When You Recommend a Specialist." I and a few of my young friends in specialties consider it an affront.

Such statements as "board diplomas . . . are a weak substitute for mature judgment" and "try to pick a [specialist] who has been out of medical school twenty years" are medical cliches and misstatements. I expect to have a "freshly printed board diploma" in the near future, as do many of my contemporaries. And M.D.'s will continue to send us patients—even their own wives—in spite of our alleged lack of "mature judgment."

Philip S. Peven, M.D.
Detroit, Mich.

What seems to disturb Reader Peven, who describes himself as "a young specialist," is the article's stress on practical experience, its de-emphasis of diplomas. Comments a 45-year-old physician (one of the twelve G.P.'s whose collective views comprise the article in question): "Maybe Dr. Peven will feel differently ten years from now."

Surgery

In your September issue, Dr. Stanley Sedlar writes: "Every time I read about restricting surgical privileges to 'safeguard the patient,' I have to laugh."

The situation is far from humorous. I agree that it doesn't take long to learn the mechanics of a routine hernia or appendectomy,

or of almost any other surgical procedure.

A trained surgeon has not spent all his residency learning these simple mechanics. He has learned *judgment*—what to do and, more important, what *not* to do when an emergency arises.

Recently an untrained surgeon entered the urinary bladder while repairing a hernia. This slip was not recognized and the patient died, following massive urinary estravasation into the peritoneal cavity. The surgical error could have been committed by any surgeon; but failure to recognize it and to see what was happening to the patient post-operatively cannot be forgiven. Emphasis on adequate training in surgery is well placed because surgery can be a lethal weapon in inexperienced hands.

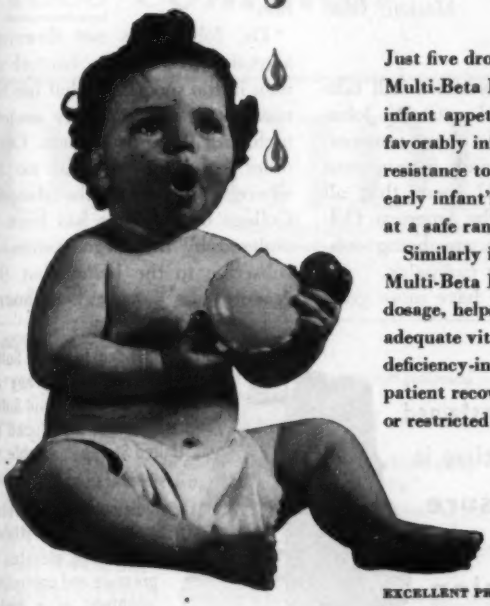
Leonard L. Cowley, M.D.
Long Beach, Calif.

Waterproof

I was surprised to read about Dr. Jac. Gillman's troubles with an electric water cooler that serves also as a storage place for pharmaceuticals. We purchased such a cooler in May, after reading about it in MEDICAL ECONOMICS, and have found that it gives excellent service.

Dr. Gillman claims that moisture collecting in the cold-storage compartment destroys the labels and boxes of vaccines. We have found the best procedure is to put the smaller boxes in one large card-

infant anorexia rapidly disappears



Just five drops daily of White's Multi-Beta Liquid stimulates the infant appetite; weight increase is favorably influenced and greater resistance to infection exhibited—the early infant's vitamin B intake is at a safe range.

Similarly in the adult, White's Multi-Beta Liquid, in teaspoon dosage, helps replenish and maintain adequate vitamin B stores—corrects deficiency-induced anorexia, aids in patient recovery, improves special or restricted dietaries.

EXCELLENT PRESCRIPTION INGREDIENT

Palatable, non-alcoholic and stable, White's Multi-Beta Liquid is ideally suited to prescription use. Compatible with such ingredients as: (1) Tincture Nux Vomica, in equal parts, (2) Elixir Phenobarbital, 1 to 4 parts, (3) White's Mol-Iron Liquid, 1 to 8 parts.

White's **MULTI-BETA LIQUID**

. . . multi-purpose **B complex** source

WHITE LABORATORIES, INC., *Pharmaceutical Manufacturers*, NEWARK 7, N. J.

board container, placing this on a little metal stand about an inch off the floor of the cold-storage compartment. In this way, the small amount of moisture that sometimes collects there doesn't reach the boxes.

Marjorie Williams
Medical Secretary
Marion, Ohio

ACS

A great many physicians will take exception to Dr. Lucius W. Johnson's recent article about unnecessary operations and incompetent surgery. It would seem that all surgeons outside the American College of Surgeons are being subjected to a smear campaign.

In Indiana, we have more good surgeons who are *not* members of the ACS than men who are. The insidious propaganda that membership in the college is a reasonable stamp of certification is not only untrue, but is unfair to those who do not choose to belong, or who prefer to belong to other organizations you do not even mention.

Dr. Johnson is not thoroughly acquainted with the control over men in the specialties that has been exerted by many county societies, including those in Indiana. On the other hand, I know of no case where a fellow of the American College of Surgeons has been disciplined by that organization. We subscribe to the belief that there is only one fair and democratic

disciplinary body for doctors—the county medical society. Our courts have supported the view that hospital staff committees are likely to be biased and self-interested.

The ACS has asserted that it has no right of control or compulsion over any doctor, or over any hospital staff. We have had enough of that claim. Our county hospitals need internes. That they cannot have internes stems directly from the fact that the American College of Surgeons and the American Hospital Association refuse to give credit to an interne who has his training outside a narrowing circle of accredited institutions. That is the kind of control exerted over small businesses by the gangsters in Chicago not too long ago.

We object to the imposition of closed-staff hospitals, the stated goal of the American College of Surgeons. We object to compulsory hospital staff meetings that destroy the county society and its long established traditional meeting. We object to a fixed, prescribed training that recognizes only a limited field for instruction. And we object to the expensive, voluminous and annoying duplication in record-keeping required by the ACS.

If there were a spirit of compromise that would give credit where credit is due, we might approach a debate with the detailmen of this institution in a spirit of friendliness. But the ACS wants to govern, guide, condemn, and control all outside its organization.

M.D., Indiana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WITHOUT WASTE

The Baxter method of collecting, storing and administering blood and plasma is a model of simplicity, safety and streamlined efficiency. The closed system, developed and introduced by Baxter, insures sterility. Baxter expendable donor and administration sets make procedure simple, safe, expedites teaching. And now the new Baxter Fezo-Flo stopper solves the aging problem, insuring trouble-free, easy-flowing infusions. A demonstration of this complete Baxter program can be arranged without obligation.

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AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES • EVANSTON, ILLINOIS

The most "persuasive" oral germicide you can prescribe

1. ***Cēpacol persuades a wide range of oral bacteria to surrender within 15 seconds after contact[1]***

2. ***Cēpacol's pleasant taste persuades your patients to use it***

The rapid antisepsis[2] and soothing relief which Cēpacol brings to inflamed, sore throats are important. Along with the fact that Cēpacol is non-irritating, non-toxic, and does not interfere with tissue healing. Too, patients are extremely grateful to you for prescribing something so effective that also is so *pleasant* to use—as either gargle or spray.

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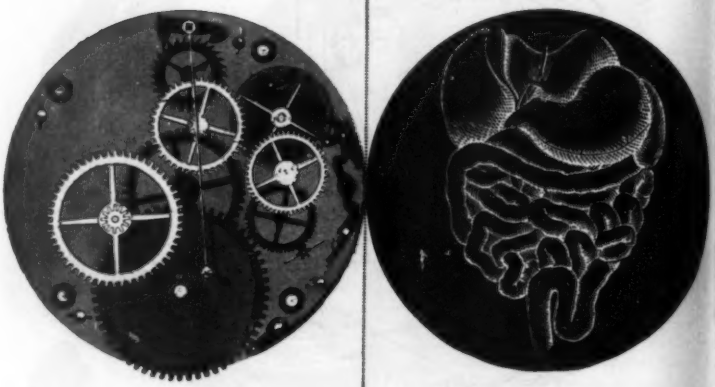

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AGORAL* PLAIN is particularly useful in cases in which intestinal irritants or cathartics are contraindicated or not required. AGORAL* PLAIN has a mild, non-irritating, gentle action. Anal seepage, a usual occurrence with mineral oil and mineral oil emulsions, does not occur with AGORAL* PLAIN.

AGORAL* PLAIN has a pleasing taste and may be taken undiluted or mixed with water, milk, or fruit juices.

AGORAL* PLAIN is indicated in all conditions where acute or chronic constipation must be corrected without strain—pregnancy, cardiovascular diseases, old age, and postsurgical convalescence.

AGORAL* PLAIN 'WARNER' is available in bottles of 16 fluidounces.

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Sidelights

'The Road Ahead'

The American people may be holding their own in the fight against communism, but they're losing the fight against socialism. And one is pretty much the same as the other.

This is the theme that John T. Flynn artfully documents in his new book, "The Road Ahead." Strewn through the pages of this provocative volume are many morsels that doctors will find of special interest—and of immediate use.

Mr. Flynn, one of this country's most articulate conservatives, shows what "liberal" Government policies have brought on in England—and what they are bringing on here. "What the American must understand," he says, "is that while each of these proposals—Federal invasion of banking, Federal invasion of power, and socialized medicine—is promoted as if it were just a single reform unrelated to all others, the simple fact is that each is intended to liquidate some sector of the private-enterprise system and expand the area of socialism. When the whole program is well advanced, we will be a socialized people upon the British model."

Precisely what the British model is, and how far we've already followed the British lead, Mr. Flynn describes in illuminating detail. He turns an unflattering spotlight on the behind-the-scenes Washington planners, on Americans for Democratic action, on the Federal Council of Churches of Christ in America, and on other groups bent on multiplying the Federal Government's power to spend, to compel, and to control.

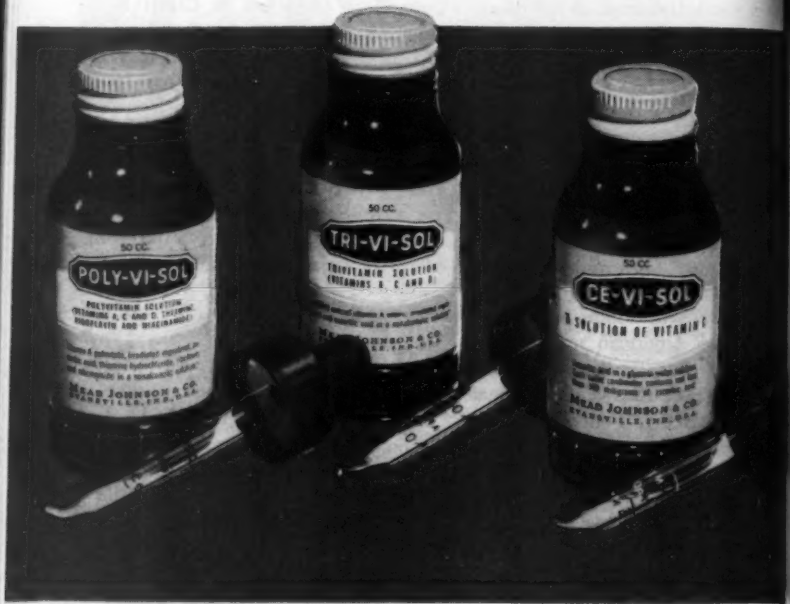
All this makes useful grist for the doctor's mill. "The Road Ahead" may not be merry enough for anyone's Christmas list, but it's sure to turn up in many a physician's political armamentarium for 1950.

Tax Tangle

Probably the mootest question doctors face in filling out their Federal income tax returns is this: What professional-entertainment costs are deductible?

As pointed out last month, the Bureau of Internal Revenue classifies the social expenses connected with the advancement of a doctor's career as legitimate, deductible expenses. But in some areas, physicians report, local revenue agents now seem intent on disallowing *all* such deductions, claiming they are

new convenience
new flexibility in dosage
new all-around usefulness



Poly-Vi-Sol

Each 0.6 cc. supplies:

Vitamin A	5000 USP units
Vitamin D	1000 USP units
Ascorbic Acid	50.0 mg.
Thiamine	1.0 mg.
Riboflavin	0.8 mg.
Niacinamide	5.0 mg.

Tri-Vi-Sol

Each 0.6 cc. supplies:

Vitamin A	5000 USP units
Vitamin D	1000 USP units
Ascorbic Acid	50 mg.

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Each 0.5 cc. supplies:

Ascorbic Acid	50 mg.

with 3 new water-soluble liquid vitamin preparations

Each of these preparations is ideally suited for routine prophylactic or therapeutic vitamin supplementation for infants and children as well as adults.

Water-soluble, pleasant tasting, they can be stirred into the infant's formula, or into fruit juice, milk, or other fluid; mixed into cereals, puddings, etc.; or incorporated in mixtures for tube feeding.

Each is scientifically formulated and ethically marketed. They are supplied in 15 and 50 cc. bottles, with an appropriately calibrated dropper.

MEAD'S

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EVANSVILLE 21, IND., U. S. A.

unprofessional by nature.

If that's the case, these local agents seem to be ignoring Federal policy. Last month this magazine checked with BIR headquarters in Washington to see whether there had been any change in the established rules. From the bureau's information officer came this answer: "Bureau policy remains same on entertainment expenses of doctors."

But from another high BIR source came a pertinent warning:

"Some doctors seem to believe that they have a pretty free hand in deducting entertainment costs. Actually, any businessman—doctor or traveling salesman—must be ready to prove that any entertainment deduction has a direct relationship to the income he earns. The deduction cannot be based on a vague theory that entertaining in general is a business expense.

"Physicians should note that several of their colleagues have recently been disallowed entertainment expenses because they could not prove that their fees resulted, directly or indirectly, from such entertainment."

On Second Thought

The typewritten letter heading the chart read: "I wish to enter your hospital because of unbearable rapture." It was all put right by a well-fitting truss.

• • •

What is so rare as a day in June? A doctor attending his patient's funeral.

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Available in pure crystal form in packages of 3.8 Gm. sufficient to make 1 gallon of 1:1000 solution or tincture; also:

Tincture	1:500	8 oz. and 1 gal. bottles
Tincture	1:1000	
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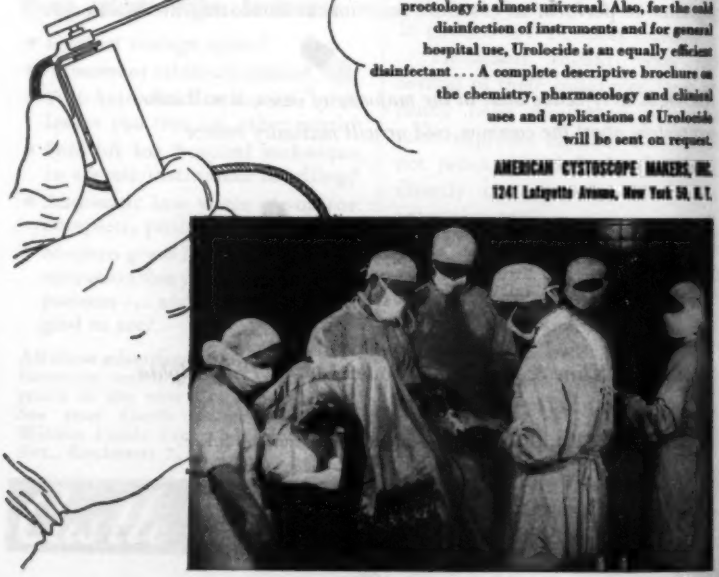

Editorial

Harry's Harpoon

• For some weeks now, Harry Truman's anti-trust sleuths have been sniffing suspiciously through medical society files. Harry would have people believe that our profession is "conspiring to destroy" all prepayment plans outside its control. Chances are, though, that people won't believe anything of the kind.

If "conspiring to destroy" has been our aim, the record indicates we've done a pretty poor job of it. More than 25 million people are currently enrolled in commercial, co-op, or union medical care plans. Our own Blue Shield plans have signed up only half as many.

But let's not quibble. Let's look ahead to some interesting end effects of the anti-trust drive:

What Harry intended as a harpoon may yet turn into a boomerang. There are plenty of indications of this in the public press. Currently it's loaded with caustic comment on the President's eagerness to pin a monopoly rap on the nation's doctors—especially as contrasted with his apathy about the union monopolies that recently crippled the country's economy.

Harry's poor press may get even worse. If, after sifting through the medical society records, his trust-busters report "no case," it's pretty sure to strengthen the public's belief that the probe itself was an out-and-out political reprisal. If, on the other hand, large numbers of doctors and medical societies are haled into court, U.S. prosecutors may find the going rocky.

Much has changed since the 1938 anti-trust case. Then, medicine was lukewarm toward health insurance, openly hostile to the co-ops. Now, medicine is vigorously supporting the voluntary approach, has passed the peace pipe to the lay-sponsored plans. In Oregon, where the first anti-trust trial is in progress, Government prosecutors are discovering these things. And there's now real doubt whether they can win a "guilty" verdict on the major points at issue.

Will this medical muckraking have any wholesome results? Surprisingly enough, it may. It will probably encourage medicine to work still more closely with the *good* lay-sponsored plans. With greater M.D. participation, they could produce a sizable enrollment boost for voluntary insurance. For Harry Truman, that could be the biggest boomerang of all.

—H. SHERIDAN BAKETEL, M.D.

Doctors, Says AM
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J. S. Views
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By Doctors
Justice Dept. Renews
Attack on 'Doctors' Trust
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INSURANCE MEN FIGHT
U. S. MEDICAL INQUIRY
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Doctors Fight Anti-Trust 'Smear'

'Conspiracy' case in Oregon sets pace for rest of U.S.

• "A politically-motivated attack intended to discredit and intimidate the medical profession," is what organized medicine calls the Justice Department's current anti-trust investigation.

The principal charge leveled at the profession is that it has conspired to restrain and monopolize the furnishing of prepaid medical care. The chief complainants are the group health cooperatives and their supporters among the public, in the Government, and in medicine. The same type of offense is being committed today, they allege, as was committed more than a decade ago in the widely publicized Group Health Association case in Washington, D.C.

Medical societies retort either that they have not hindered the co-op medical plans at all or that they have opposed only those they felt posed a threat to medical standards. The AMA Board of Trustees, in an official statement, says:

"We would be naive, indeed, if we ignored the political implications of this sudden rash of investigations, attacking medical societies at a time when the Administration is doing its utmost to stifle opposition to its proposed system of Government-controlled medical care.

"We want it clearly understood that we believe this attack on the medical profession stems from the Anti-Trust Division of the Justice Department and the political string-pullers who have exerted influence on that agency. We believe it to be an outrageous abuse of

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Justice Department's Attorney General J. Howard McGrath (left) joins hands with Senator James E. Murray (center) and Representative John D. Dingell. McGrath has been given job of sparking anti-trust suits against organized medicine.

Bad publicity for the profession, created by Government prosecution, was expected to hinder voluntary health insurance plans sponsored by doctors and to help compulsory Murray-Dingell plan sponsored by Administration. But vigorous counter-publicity issued by medical associations is proving an effective antidote.

"During the February session of the Board of Trustees, in the early hours of February 10," says an AMA statement, "the board room [▲ at AMA headquarters ➤] was broken into and records of the board were thoroughly seached by persons unknown. Briefcases of the trustees,* left in the room, were also searched. The facts indicate that this was a search for information, rather than an ordinary burglary." Commented the Columbus (Ohio) Evening Dispatch in a recent editorial: "If Justice Department agents are responsible for this, it represents a new low in Government morality."

public power which far transcends in gravity the issue of compulsory health insurance, vital as that issue is."

Most of those in medicine's camp see the same implications in the anti-trust probe that the trustees see. But opinion is not unanimous. A representative of the law firm of William J. ("Wild Bill") Donovan, wartime OSS head, who is currently representing the Medical Society of the State of New York, says: "Investigations of this kind are made by the Department of Justice all the time and among all sorts of industries and organizations. They're quite routine."

Assistant Attorney General Herbert A. Bergson labels as "absolutely false" the charge that the anti-trust investigations were politically inspired.

The cases were, he told MEDICAL ECONOMICS, "inspired only by the fact that violations of the Sherman Act had been cited by doctors and by the consuming pub-

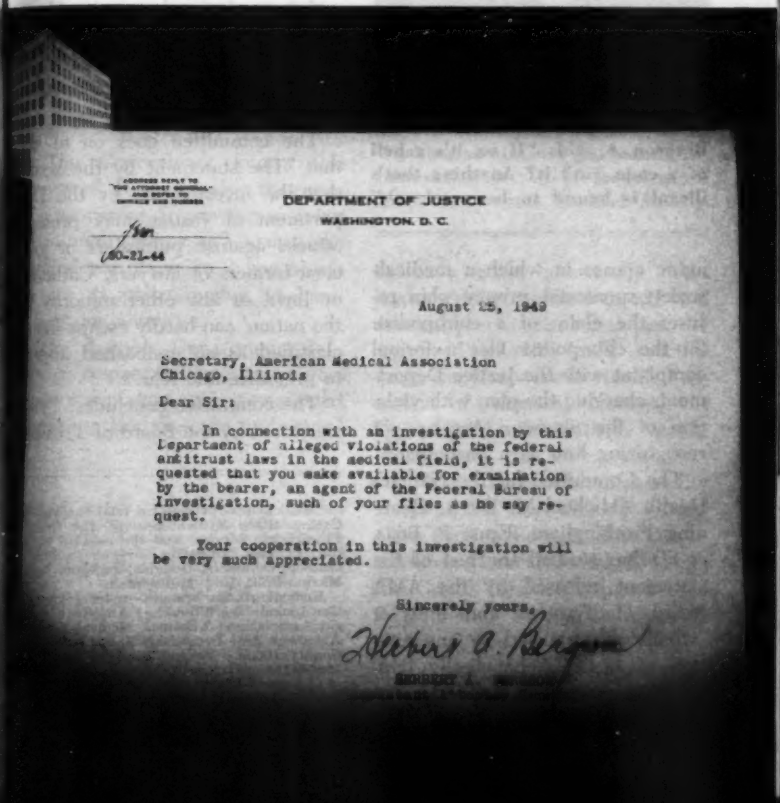
*Shown (clockwise) in this board-room photograph are Dr. William Bates, Dr. R. B. Robins, Dr. John W. Cline, Dr. Walter B. Martin, Miss Leone Baxter, Dr. E. E. Irons, Mr. Clem Whitaker, Dr. Louis H. Bauer, Dr. Elmer L. Henderson, Dr. Edwin S. Hamilton, Dr. George F. Lull, Miss Sirio, Dr. Gunnar Gundersen, Dr. James R. Miller, Dr. R. L. Sensenich, Dr. Frank Wilson.

lic. We have literally hundreds of complaints on file."

"Maybe the Justice Department *has* a number of complaints on file," a medical society secretary has said. "But it doesn't necessarily mean anything. An Attorney General who wants to press charges against a profession or other group can easily find justification. In medicine's case, an invitation relayed by the grapevine to groups made up of left-wing physicians and laymen would have brought forth more than the necessary number of complaints.

"No doubt a good many of the complaints in the present instance have come from fly-by-night organizations and individuals that organized medicine would never in a hundred years approve and that no one in his right mind would expect it to approve.

"Some of the allegations are pretty silly anyway. You can im-



DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

60-21-44

August 25, 1949

Secretary, American Medical Association
Chicago, Illinois

Dear Sir:

In connection with an investigation by this Department of alleged violations of the federal antitrust laws in the medical field, it is requested that you make available for examination by the bearer, an agent of the Federal Bureau of Investigation, such of your files as he may request.

Your cooperation in this investigation will be very much appreciated.

Sincerely yours,

Herbert A. Bergson

HERBERT A. BERGSON

Asked if he thought the anti-trust law and the code of medical ethics might not be incompatible, Assistant Attorney General Herbert A. Bergson A said: "If so, it's a hell of a code, isn't it? Anything that's illegal is bound to be unethical."

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agine a case in which a medical-society-sponsored prepay plan refuses the claim of a chiropodist. So the chiropodist files a formal complaint with the Justice Department, charging the plan with viola tion of the Sherman Act by not recognizing him as a participant."

The Committee for the Nation's Health (Michael M. Davis, Channing Frothingham, Ernst P. Boas, *et al*) has studied the text of the statement released by the AMA Board of Trustees and finds it "wholly unsupported by any citation of facts." What really happened, it charges, is that "The Department of Justice has received complaints over a considerable period of time from physicians and patients, indicating that certain medical societies* were using professional pressures and other means to maintain monopolistic control over the supplying of medical care. Receipt of such complaints, supported by reasonable statements of fact, imposed an obligation on the Department of Justice to investigate.

"For the Board of Trustees to charge the Department of Justice with misuse of its powers—without marshalling reasonable proof—casts a serious reflection upon the judgment of those issuing the statement."

The committee goes on to say that "The statement by the board that the investigation by the Department of Justice may presage attacks against 'publishers or grocers, farmers or lawyers, Catholics or Jews, or any other minority in the nation' can hardly escape being classified as an unabashed appeal to prejudice and fear."

The committee concludes: "This statement by the Board of Trustees

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*Medical groups now on trial include the Oregon State Medical Society, the Oregon Physicians' Service, and the medical societies of the following Oregon counties: Clatsop, Columbia, Douglas, Jackson, Lane, Marion-Polk, and Multnomah.

Medical groups brought under investigation include the following: American Medical Association; Arkansas Medical Society; Arkansas Blue Cross-Blue Shield; Beckham County (Okla.) Medical Society; California Medical Association; Academy of Medicine of Cleveland (Ohio); Columbus (Ohio) Academy of Medicine; Harris County (Texas)

realizes the worst fears expressed some months ago by 148 of America's most distinguished physicians" (see April MEDICAL ECONOMICS, page 135).

Dr. Francis F. Borzell, speaker of the AMA House of Delegates, brushes aside such explanations of the Justice Department's action: "This is a concerted, nation-wide attempt to harass organized medicine in its efforts to give the public voluntary sickness insurance. We recognize, of course, that such insurance is our best answer to proposals for Federal medicine; and in this sphere we have made phenomenal strides—particularly in the last year or so.

Work 'Hamstrung'

"The Government knows this story well. It knows, also, that popular sentiment is growing in favor of voluntary plans and against the compulsory plans. So it has begun to use its police power to hamstring our activities."

The Justice Department does not, of course, indicate the sources of its complaints against organized medicine. But they are understood

"If they can slap a big fine on some Oregon doctor, or jail him for a year, they'll silence a lot of opposition to the Truman health program," said a Washington observer last month. Dr. James Buckley ▲ is president of the Oregon State Medical Society.

to have come principally from health groups, medical co-ops, and medical prepay plans that lack the organized profession's sanction (*e.g.*, the Cooperative Health Federation of America, Chicago; the Committee for the Nation's Health, Washington; the Physicians' Forum, New York; the Community Hospital, Elk City, Okla.; the Complete Service Bureau, San Diego; the Civic Medical Center, Chicago, the Group Health Cooperative of Puget Sound, Seattle; the Farmers Union, Williston, N.D.).

The co-ops' primary charges are: (1) Organized medicine has

Medical Society; Ingham County (Mich.) Medical Society; King County (Wash.) Medical Society; Los Angeles County (Calif.) Medical Association; Michigan Medical Service; Michigan State Medical Society; Nassau County (N.Y.) Medical Society; Medical Society of the County of New York (N.Y.); Medical Society of the State of New York; Oklahoma State Medical Association; Medical Society of the County of Queens (N.Y.), Inc.; Summit County (Ohio) Medical Society; Utah State Medical Association; Washington State Medical Association; Wayne County (Mich.) Medical Society.

Data Sought by Justice Department

Information requested of one county medical association by the Anti-Trust Division follows:

A. Organizational set-up of the medical society, including:
   1. Constitution and by-laws
   2. Names of officers
   3. List of committees, boards, bureaus, or other bodies within the organization

B. Review of all files including correspondence, minutes of meetings, memoranda, etc., pertaining to:
   1. Medical economics, prepaid medical plans, contract practice of medicine
   2. Group hospitalization policies or contracts, as well as references to practice of medicine by hospitals
   3. Correspondence between your society and the American Medical Association or any other national or local medical society
   4. Conditions or rules of eligibility necessary:
      a) To become a member of your medical society
      b) To take specialty board examinations
      c) To use the facilities of hospitals approved or used by your society
   5. Code of ethics of the society
      a) Disciplinary action as to members
      b) Suspension or expulsion of doctors from your society
      c) Rejection of applicants to your society
   6. Occupancy or efforts to occupy office space by doctors in the various medical buildings
   7. Publications and literature published by your organization
   8. Formation of doctor-sponsored prepaid medical care, with the details of any such plan
      a) Legislation or proposed legislation on prepaid medical care
   9. Malpractice insurance
   10. Doctor employment agencies

used its influence to secure discriminatory legislation in more than twenty states. This legislation allows the medical societies to operate prepay plans but denies the same right to the co-ops.

(2) Medical societies bar or expel physicians from membership because of association with medical co-ops. These doctors are thus denied (a) free access to hospitals, (b) the consultive services of society members, and (c) the other privileges of membership in organized medicine.

(3) The specialty boards, taking the same point of view, deny certification to co-op doctors.

Real Reason for Probe

Most medical men interviewed last month felt that while the foregoing complaints might well explain the co-ops' enthusiasm for anti-trust investigations of the profession, the Government's aim in making the investigations was to put doctors in an unfavorable light with the public, thus tending to discredit medicine's voluntary insurance plans and to boost the Administration's compulsory scheme.

Said one physician:

"Whenever the Government, in its opposition to organized medicine, can drag out something like an anti-trust case, it means a lot of free publicity. If this does no more than tarnish the private doctor's respectability and dim public confidence in him, it's well worth the effort.

"The Attorney General would like to show that the doctors are a bunch of tradesmen anyway and that they're trying to hold out on the public. So he encourages the suspicion. He figures people will say, 'Where there's smoke there's fire; so maybe the Government *ought* to investigate the doctors.'"

A number of physicians, in talks with MEDICAL ECONOMICS, have commended the AMA Trustees for their vigorous and courageous offensive against what the board called "a campaign to discredit American medicine and terrorize physicians into abandoning their opposition to compulsory health insurance."

Some of these practitioners emphasize, however, that courage on the part of the trustees is not enough; that the situation demands equally aggressive action by local medical associations and their members.

Local Aid Sought

"Urge doctors to assert themselves," said a county medical society president. "Let them take their case to the press and give the public the true facts. It's up to the local men to take the initiative in protesting this abuse of public power."

About the attitude of Attorney General J. Howard McGrath toward the medical profession, Dr. R. B. Robins of Camden, Ark., Democratic National Committeeman from Arkansas and a member

Rulings in the 1938 Anti-Trust Case

"The common law governing restraints of trade has not been confined, as defendants insist, to the field of commercial activity ordinarily defined as 'trade.' It embraces as well the field of medical profession . . . We must hold that a restraint imposed on the lawful practice of medicine and on the operation of hospitals and of a lawful organization for the financing of medical services to its members, is just as much in restraint of trade as if it were directed against any other occupation or employment or business."

—U. S. Circuit Court of Appeals

"Defendants say that under their rules disobedient members may lawfully be disciplined and that disciplination does not amount to unreasonable restraint . . . We recognize that the rules and canons so established have aided in raising the standards of medical practice, to the advantage of the whole country . . . Notwithstanding these important considerations, it cannot be admitted that the medical profession may, either by rule or disciplinary proceedings, legally effectuate restraints as far-reaching as those now charged."

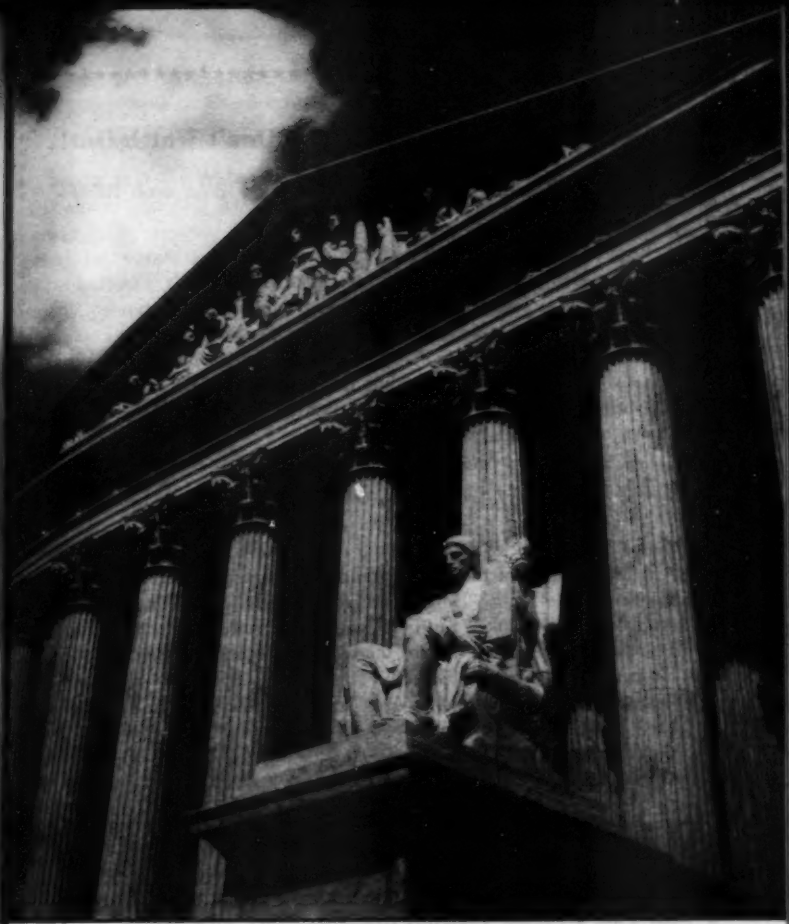
—U. S. Circuit Court of Appeals

"In truth, the [medical societies] represented physicians who desired that they and all others should practice independently on a fee-for-service basis . . . These independent physicians, and the two petitioning associations which represent them, were interested solely in preventing the operation of a business conducted in corporate form by Group Health."

—U. S. Supreme Court

of the AMA House of Delegates, says this:

"As a United States Senator, Mr. McGrath was one of the leading advocates of compulsory health insurance and one of the most intemperate, vitriolic critics of the American medical profession. As chairman of the Democratic National Committee, he misused the facilities of that committee to make scurrilous, slanderous accusations against state medical societies and the American Medical Association.



And now, as Attorney General, he has gone even further by using the facilities of the Department of Justice for political purposes."

In July 1947, while a Senator from Rhode Island and a co-sponsor of the Murray-Dingell bill, Mr. McGrath told the Senate's health sub-committee that "AMA spokesmen evidently agree on the provision which makes it possible for a state to designate one and only one prepayment plan as the recipient of Federal funds . . . The AMA

The FBI Will Git You Ef You Don't Watch Out!

By Tom Hendricks, with a bow to James Whitcomb Riley

J. Edgar Hoover's come to AMA to stay—
To scrutinize our records an' cause us all dismay,
To probe into our papers an' snoop around a heap,
To analyze our thinkin' an' the company we keep.
Then all us bad "monopolists," when supper-time is done,
We set around the radio an' has the mostest fun
A-listnin' to the witch-tales 'at McGrath tells about:
How the FBI will git you
Ef you
don't
watch
out!

Wunst there wuz a doctor who'd allus scoff an' sneer
An' say that social medicine would *never* happen here.
He defied the British Empire, Mister Bevan's social state,
An' vowed his Yankee brothers would not share that tragic fate.
But as his awful blasphemies made blue the office air,
He turned an' saw two G-men a-standin' by his chair.
They quickly checked his records 'fore he knew what he's about.
Now the FBI will git *you*
Ef you
don't
watch
out!

So allus make your night calls though the bills are overdue,
An' your bed is soft an' comfy an' the wind outside goes woo-oo!
You can hear Jack Ewing rantin', you can hear Mike Davis bray,
An' Falk a-spoofin' Congress that folks won't have to pay.
So you'd better watch your patients, an' mind your P's and Q's,
Attend your county meetin's, an' pay your annual dues.
An' warn your friends an' neighbors, ef the doctors take the count,
How the FBI will git *them*
Ef they
don't
watch
out!

no longer acts in the interest of either the people or the doctors."

AMA's Answer

Charges that the AMA discriminates against prepaid medical care plans outside its own control are denied by association spokesmen. As evidence of the parent body's impartial stand, they point to the physician-service insurance contracts covering its own employes. These contracts were written by a commercial insurance company and not by Blue Shield.

E. H. O'Connor, managing director of the Insurance Economics Society of America, says: "If the medical profession were attempting to monopolize prepaid medical care, it would mean that the American Medical Association and doctors in general were opposing private insurance companies that sell policies covering hospital, medical, and surgical expenses.

"Actually, the medical profession is doing just the opposite. The AMA is making a nation-wide effort to promote *all* types of voluntary health insurance. There is open, wholesome competition between insurance companies and medical care plans sponsored by physicians and hospitals."

FBI Activity

It was estimated last month that perhaps two dozen agents of the Federal Bureau of Investigation had been assigned the job of checking the records of medical societies, prepayment plans, and individuals. No doubt the number was at least that, since investigations were going on more or less simultaneously in twenty-two widely separated sections of the country, and since from one to five agents were required for each inquiry.

An FBI man who had worked on the anti-trust probe in one area but had retired recently to a job with a private firm, was reported as saying that the Government attorneys opposing organized medicine didn't have a leg to stand on. Agents still with the FBI would, of course, voice no opinion on the merits of the case. One of them, twitted by some doctors to the effect that he'd probably soon find himself being told to investigate the churches, could only smile wryly in reply. He was one of several who showed little enthusiasm for the idea of helping pin a rap on the nation's doctors.

Some medical societies under investigation have offered their records freely to the G-men. Others have declined to do so without being subpoenaed.

One association, on receiving a general request to inspect its files, asked what specific types of material the Government agents wanted. Because this was too large an order, or because of some other reason, the inquiry lapsed. Another society that also asked the FBI to particularize its request received a detailed list of information wanted (see accompanying

box) and is now trying to supply the data. Still another association said its attorneys had advised it not to make its records available; whereupon the agents left and never came back.

Five G-men began an extended examination of records at AMA headquarters in early October, using the trustees' board room as their workshop. They were expected last month to remain on the job until after New Year's.

Three AMA attorneys, working in relays, have been keeping the FBI agents company. Files have to be brought to the board room from different parts of the building. Notes have to be made of material being examined. It's a long process and an expensive one to the AMA.

Resort to Microfilm

It was apparent within the first week of the AMA probe that the volume of material the G-men wanted would be monumental. Arrangements had to be made, therefore, to microfilm most of the extracted records.

The Government agents in Chicago have even gone so far as to request copies of speeches made by AMA officers and to pore over the routines of the Council on Pharmacy and Chemistry. What these things have to do with an anti-trust investigation, AMA heads are at a loss to explain.

The anti-trust case in Oregon illustrates the methods employed and the allegations made by the Department of Justice against organized medicine. The Oregon investigation began in October 1947 and was completed in May 1948. After that, nothing happened officially for several months ("for the simple reason that they didn't find anything," says an Oregon doctor). Last fall, however, Mr. Truman determined to go all out for compulsory sickness insurance. It was decided then, apparently, that the Oregon situation might be ammunition in the political campaign.

Oregon Crack-Down

On Oct. 18, 1948—on the eve of the national election—the Attorney General announced to the press in Washington the initiation of a suit by the Government against the Oregon State Medical Society, the Oregon Physicians' Service, several county medical societies in Oregon, and officers of those organizations.

To get the full benefit of advance publicity on the suit, Oregon doctors charge, the Department of Justice waited twenty-four hours after its announcement to the press before it served papers on any of the defendants in Oregon. The latter got their first inkling of what had happened when local newspapers began calling for details.

Nature of 'Conspiracy'

The summons issued by the U.S. District Court for Oregon called upon the defendants to appear in answer to charges that they had:

"a. Hindered and obstructed

Cartoonist Berryman should have labeled Mr. Truman's pickaxe, "Anti-Trust Probe," say Washington doctors who saw this drawing in the Star.

prepaid medical care organizations in their attempts to secure and retain qualified doctors to cooperate with them.

"b. Expelled, threatened, and incited the expulsion from medical societies of doctors cooperating in prepaid medical care plans other than those sponsored or approved by the defendants.

"c. Formed and promoted their own prepaid medical care plans with the intent to drive out, hinder, and obstruct other commercial medical care plans operating in the State of Oregon.

"d. Interfered with commercial prepaid medical care organizations other than those sponsored or approved by them in obtaining hospital facilities for their members.

"e. Refused to treat patients and caused others to refuse to treat patients who are members of a prepaid medical care plan not endorsed by defendants, unless the patient pays cash.

"f. Refused, and encouraged other doctors to refuse, to give patients [in] pre- [*Continued on* 133]

Your Liability i Expe

The patient's consent is vital, but it doesn't cover everything. Here's why—

● Some years ago, when many X-ray procedures were still experimental, a Missouri physician was sued for burns inflicted on a patient he was treating for eczema. The doctor had warned him of the hazards of X-ray, even refusing treatment until the patient had assumed "all known and unknown risks." It was shown at the trial, however, that the patient had been placed too close to the machine.

The doctor was found guilty of malpractice.

The court held that a patient cannot legally assume the risk of a doctor's negligence. Said the judge: "Consent means nothing unless due care and skill are em-

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******The authors, Dr. George I. Swetlow and Marvin G. Florman, are practicing attorneys. Dr. Swetlow practiced neuropsychiatry for several years, turned to law in 1931; he is professor of medicolegal jurisprudence at Brooklyn Law School. Mr. Florman is his associate.*

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ployed by the physician." The doctor was guilty—not because he had experimented, but because he had failed to experiment properly.

This principle still holds. Many of the older cases of medical jurisprudence are among the best guideposts available to the doctor of today. Where medicine is progressive, groping constantly into the future for new tenets, the law is conservative, relying on precedent. The practice of medicine modified by law has long been established as serving the best interests of the patient.

In experimental therapy, the first rule is, of course, to make certain the patient understands that it *is* experimental. A midwestern orthopedist, reducing a fractured tibia, attempted a new method calculated to improve the bone alignment. He first went carefully into the rationale with the patient, who then gave his assent. But when things didn't work out, the man sued—and won.

What the doctor had neglected to disclose was that the procedure was of his own devising, that no other physician had yet attempted it. In short, that it was highly experimental.

Where does experimental therapy end and orthodox treatment begin? Treatment is not experimental, a New York court has ruled, if "the cases in which it was tested were substantially the same [as the case at hand] and the treatment has been successful in so many instances as to establish the propriety and safety of adopting it."

Therapy from Journal

Mere newness of a therapeutic procedure does not mean it's still experimental. A Michigan G.P., faced with the prospect of amputating a patient's bone-diseased foot, called in a specialist. Trying to save the foot, the specialist adopted a line of treatment that had just been reported in his specialty journal. The treatment failed, and the foot had to be amputated. The patient, charging unauthorized experimental therapy, haled the specialist into court.

The verdict was for the doctor. Though the treatment was novel, it had passed the experimental stage. It had been successfully used in similar cases by more than one physician. Results had been published in a professional periodical of recognized standing. The court observed that practitioners of a reputable school of medical thought

are not to be harassed by litigation merely because their ideas are new or their group a minority.

"Due regard," said the judge, "must be given to the present advanced state of medicine. Any improvement of methods will almost always emerge as a departure from what the majority of physicians have heretofore held."

The trail-blazing practitioner, however, is always courting a brush with the law. Most juries tend toward compensating damage-seeking plaintiffs. Which means that the M.D. who veers even slightly from the straight-and-narrow of established therapy had better be prepared to prove that he used extra care and diligence.

A New Twist Fails

Take the ENT man in California who undertook an alcohol-and-novocaine injection of an asthma patient's nasal ganglion. He decided to reverse the usual procedure of injecting the novocaine first, followed by the alcohol. In carrying out the treatment, he pierced the bony structure between the right nostril and the right orbit; not until later did he learn that this bone wall had been partly removed in a previous operation. The alcohol was injected where it could damage the optic nerve, and the patient lost the sight of his right eye. He sued, charging unwarranted experimentation.

The jury found for the patient, assessing the doctor $15,000—though less for experimentation than for failure to use extra diligence.

The fences that the law builds around experimental therapy also help to keep out quacks. The doctor must be prepared to prove that his treatment makes medical sense. For example, an Illinois practitioner advertised in the papers that he could remove smallpox pittings. A patient forked over $125 and submitted to the doctor's "painless" carbolic-acid treatment. In the resulting suit, the doctor was held guilty because he knew *or should have known* that such treatment was medically absurd.

But it's the borderline cases involving reputable physicians that present the real posers. What can the well-intentioned medical man, convinced that an experimental approach is warranted, do to protect himself?

Here are four recommended steps:

¶ Get the patient's consent in writing.

¶ Be sure the document he signs makes clear that the treatment is experimental; be sure it states the risks entailed.

¶ Obtain corroboration from other qualified physicians on the advisability of the experiment.

¶ If possible, have one or two other qualified physicians witness any experimental surgical procedure, to attest your skill and diligence.

—GEORGE I. SWETLOW, M.D., LL.B.
MARVIN G. FLORMAN, LL.B.

Will Our Medical Schools Be Next?

S. 1453 would set pattern for nationalization of all professional schools

• Recent statements by Senators Thomas, Humphrey, and Douglas indicate lessened pressure for immediate passage of the Administration's omnibus national health bill. This has lulled some doctors into a false sense of security. Not enough publicity has been given to Representative Dingell's comment that the aim is now to enact the program piecemeal, *a section at a time.*

An example of this new approach is the so-called Emergency Professional Health Training Act of 1949 (S.1453 and H.R.5940) This measure lays the groundwork for complete nationalization of our medical, dental, nursing, osteopathic, optometric, and public health schools.

Growing concern over deficit spending by the Federal Government has caused a number of physicians to re-examine their position on this school-subsidy bill and on other health legislation. Such re-appraisal has been sharply stimulated by John T. Flynn's current book, "The Road Ahead." In this book, Mr. Flynn calls attention to the close parallel between (1) the eighty-year chain of events leading to present-day socialism in Britain and (2) the more rapid but less noticed sequence of events toward the same end in the United States.

Many who oppose the Administration's omnibus health bill (S.-1679) have failed to oppose S.-1453. They seem not to have noticed that S.1453 is lifted, with only minor changes, from the omnibus bill.

Medical School Czar

S.1453 maps out a system of Federal grants-in-aid to medical schools. In Section 373 (a) is the following significant statement: "The Surgeon General, after obtaining the advice and recommendations of the council, shall make such grants in the order of the estimated importance . . ." The council referred to is advisory only; so all power is vested actually in one man, the Surgeon General. He

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* *Dr. James E. Buckley, author of this article, is president of the Oregon State Medical Society.*

would estimate needs, authorize funds.

Of even greater significance is the parade of weakness this bill would require on the part of the medical schools. Each school would compete with the others in trying to show "proof of need" in the political scramble for Federal Government funds.

Testimony presented at congressional hearings has consistently emphasized the schools' inadequacy, rather than their strength. No doubt this testimony was offered in good faith; yet it follows closely the policy of the socializers in accumulating admissions of weakness that will discredit our free institutions.

Sponsors of S.1453 have told Congress that their bill not only would save the country's medical schools from financial ruin but would relieve the "acute shortage" of doctors. A Senate debater for S.1453 said that a chief cause of the "shortage" was a "hiatus of about six years when very few medical men were trained"; but recently compiled figures indicate that there was no "hiatus." The augmented war program, in fact, graduated many more physicians than usual. In the five-year period 1937-1942 there was a net increase of 6,920. In the succeeding five years (1942-1947) there was a net increase of 16,442.

Too Few Doctors?

Talks with state medical society secretaries indicate, moreover, that the scarcity of rural doctors, aggravated by the war, is rapidly being relieved. No one doubts the excessive number of physicians in some cities. But many of our medical societies are doing excellent work in showing young physicians the advantages of small-town practice and in helping them to become established in such towns.

A leading statistician has spotlighted a related factor, and a frequently overlooked one: namely, the increased medical-care output of today's average physician. The physician is likened to a quarterback calling sig- [*Continued on* 122]

Ready or Not

• The physician was about to enter his examining room when the nurse, from inside, said: "Don't come in yet, Doctor." The doctor wanted to know why not, and the nurse explained: "The patient is in her underclothes." There was a brief pause. Then the nurse called out: "It's all right to come in now. She has them off."

—S. R. GREENBLAT

What to Look for in Open-End Trusts

Investment goals, past performance are key factors in selection of shares

• Over the years, closed-end* investment trusts have done slightly better by their shareholders, in capital growth and income payments, than have mutual, or open-end*, companies. Yet doctor-investors and others have shown a marked preference for the latter. Some reasons:

¶ *Liquidity.* Unlike most stocks, with their touch-and-go market prices, open-end trust shares may be cashed in at any time, in any amount, at a known figure. Most companies announce share prices twice daily, based on the latest value of their security portfolios.

¶ *Service.* Some open-end companies offer savings-and-investment programs designed to help you invest regularly and advantageously via dollar averaging. Some offer formula-timing plans.

¶ *Selection.* Through combined purchases of several of the many types of mutual funds available, you can fashion an investment program suited exactly to your own aims.

These aims—based on your personal decision to invest primarily for capital gain, or for income, or for safety, or for a combination thereof—are the logical starting point in the selection of open-end shares. For it's vital that the investment goals of the trusts you pick jibe with your own goals.

Aims and Methods

The last column of the accompanying table shows in capsule form the aims and operating methods of the nineteen largest diversified common stock funds and the ten largest balanced funds. But capsules can be dangerous. *Don't* gulp these down without reading the label on the box—*i.e.*, the fuller, clearer explanation of each trust's goals and methods, to be found in its prospectus. The brief remarks in the table are intended merely as a preliminary guide, not as a basis for final decision.

That holds also for the table as a whole. It doesn't pretend to chart

*The closed-end trust has a fixed capitalization, like any ordinary business corporation; to buy into it, you place an order with your broker for purchase of the shares in the public security market. The open-end trust has no fixed capitalization; its shares are not bought and sold via the security markets; instead, the trust sells its stock direct to investors, issuing new shares as needed and buying them back at any time, on demand.

the entire open-end trust field. For space reasons, it excludes funds of less than $5 million assets, though some of these are among the best managed. And because most doctor-investors are interested chiefly in diversified (multiple-industry) common stock and balanced funds, the table makes no attempt to list the dozens of funds that limit their investments to single industries or to single classes of senior securities.

This means omitting such well-reputed units as Chemical Fund, Inc., the various industry funds managed by Group Securities, Inc., the single-class funds of Keystone Custodian Funds, Inc., and others. These funds are for people who have very special objectives or who want to handle their own industry-diversification and market-timing problems.

How to Use Table

The doctor-investor, having narrowed the list of trusts to those whose objectives match his own, may well compare them then on other grounds. For instance, the first two columns of the table, giving the year of organization and the size of each fund, offer a clue to management seasoning and the comparative popularity of the funds among investors.

But remember that managements are subject to change and that mere size in a trust may reflect little more than aggressive sales promotion.

Other columns of the table

"Well, anyhow, at least your heart's in the right place."

should be read with similar reservations:

Recent Price. A low-priced stock isn't necessarily a cheap stock, so try to avoid comparing open-end trust share prices. The important relationship is that which exists between (1) price and (2) dividend income and capital gains. Recent share prices are quoted here as an approximation of recent per-share asset values, on which they are based. (Price equals asset value plus loading charge.)

Loading and Redemption Charges. The "load" on mutual trust shares (included in the quoted price) is the salesman's or dealer's commission. It's analogous to brokerage commissions on the purchase and sale of open-market shares. Since loading (and redemption) charges are likely to offset income in the first year or two, open-end shares should be bought only for long-term holding.

Note that shares of the Loomis-Sayles Second Fund, if held more than three years, and those of the Scudder, Stevens & Clark Fund, carry no loading charges at all. Both are managed by leading investment counsel firms; they have no salesmen or dealer organizations; they sell their shares only on direct application from interested investors. Note, too, that most of the other trusts scale down their loading charges on large individual purchases—say, of $25,000 or more.

Price Volatility. These figures are a rough measure of the speculative

The Doctor Takes a Quiz

● Medical men come to accept the professional examination the way a downtrodden wife takes her Saturday-night beating. She doesn't like it, but it's part of the life she's chosen.

The doctor's dilemma—to pass or not to pass?—commences with his medical aptitude test. It continues through the innumerable exams of medical school, and pursues him far into professional life. He comes up against interne and resident exams, the state board, the national board. Somewhere along the way he usually submits to the special inquisitions of the Army, the Navy, the PHS, or the Civil Service. Specialty board or American College examinations are the *creme de la creme,* served up last.

Like Pavlov's dog, the well-examined M.D. develops conditioned reflexes, attuned to the examination bell. His attitudes and reactions become fixed, and have been catalogued [*Continued on* 149]

29 DIVERSIFIED OPEN-END INVESTMENT TRUSTS

(For interpretive comment, see article text)

Common Stock Funds	*Year Organized*	*Assets* (Millions)*	*Recent Price*	*Loading Charge*	*Index of Price Volatility*	*Ratio of Mgmt. Expense to Assets**	*Income Return**	*1937-48 Performance*	*Aims and Methods***
Affiliated Fund	1934	$ 75.2	$ 4	7.5 %	155	0.79%	6.2%	131[7]%	G, I. Leverage via bank loan.
Boston Fund	1931	33.7	22	7.5	80	0.71	4.4	44	S,G,I. Some bonds, preferreds.
Broad Street Investing	1929	9.4	17	7.5	135	0.61	5.6	71	G,I. Holds some bonds.
Bullock Fund	1932	5.7	19	8.67	146	0.71	5.2	36	G, I. Invests for long-term gains.
Dividend Shares	1932	60.0	1-2	8.67	107	0.75	4.5	49	I,G. Blue chip dividend payers.
Fidelity Fund	1930	19.2	27	7.5	122	0.68	6.6	129[9]	G,I. Some speculative bonds, preferreds.
Fundamental Investors	1932	32.1	15	8.75	144	0.70	5.3	97	G,I. Aggressive-defensive operations.[10]
General Capital	1929	9.3	53	7.0	86	0.68	0.0[6]	57	G. Occasionally buys bonds, preferreds.
Incorporated Investors	1925	61.6	23	7.5	145	0.60	6.7	68	G,I. Aggressive-defensive operations.[10]
Investment Company of America	1935	5.4	27	8.0	141	1.08	4.9	83	G,I. Confined to special stock list.
Investors Management Fund	1936	9.1	14	2.0[1]	144	0.99	5.3	62	G,I. Aggressive-defensive operations.[10]
Knickerbocker Fund	1938	7.8	[illegible]	8.7	160	1.12	5.2	39[9]	I,G. Aggressive-defensive.[10] Heavy industries.
Loomis-Sayles 2nd Fund	1934	8.0	49	2.0[2,4]	101	0.77	3.7	68	G,I. Aggressive-defensive operations.[10]
Massachusetts Investors 2nd Fund	1932	15.8	13	7.5	136	0.56	4.8	56	G,I. Invests for long-term gains.
[illegible]	1924	207.0	22	7.5	111	0.40	5.8	54	I,G. Conservative, blue
National Investors	1937	13.5	10	7.5	144	0.62	5.5	126[9]	G,I. Invests for long-term gains.
Selected American Shares	1933	14.7	11	7.5	140	0.75	5.5	37	I,G. Mostly blue chip dividend-payers.

Massachusetts Investors 2nd Fund	1932	15.8	13	7.5	136	0.86	4.8	86	G,I. Invests for long-term gains.
Massachusetts Investors Trust	1924	237.2	52	7.5	111	0.49	3.9	54	I,G. Conservative, blue chip.
National Investors	1927	15.5	10	7.5	144	0.62	5.2	125[10]	G,I. Invests for long-term gains.
Selected American Shares	1933	14.7	11	7.5	140	0.75	5.8	87	I,G. Mostly blue chip dividend-payers.
State Street Investment	1924	63.6	54[5]	1.0[2,4]	68	0.59	4.3	86	G,I. Seeks out "special situations."
United Income Fund	1940	16.6	10	8.0	122	1.02	7.4	110[11]	I,G. Dividend-payers only.
Balanced Funds									
American Business Shares	1932	32.5	4	7.5	94	0.84	4.8	94[12]	S,G,I.
Axe-Houghton Fund	1934	8.0	8	7.5	144	1.12	5.3	109[13]	G,S,I.
Commonwealth Investment	1932	5.4	6	8.0	101	0.85	4.3	76	G,S,I. Ultra-diversification.
Eaton & Howard Balanced	1932	37.0	28	6.0;0.5[2]	73	0.61	4.2	77	S,I,G.
Investors Mutual	1940	126.6	13	7.5	70	0.58	4.6	96[14]	S,I,G.
Nation-Wide Securities	1933	11.1	15	6.75	71	0.60	5.0	23[15]	S,I,G. Formerly stock fund.
National Securities Income Series	1940	11.9	4-5	8.5	84	0.89	7.2	82[16]	I,S,G. High-yield securities.
George Putnam Fund	1937	26.7	16	7.0	74	0.76	4.5	78[17]	S,I,G.
Scudder, Stevens & Clark Fund	1928	24.4	50	None	75	0.75	4.1	58	S,G,I.
Wellington Fund	1928	64.1	19	8.0	59	0.78	4.0	73	G,S,I.

*1948. **Aims are indicated thus: S (safety), G (gain), I (income). Aims are given in order of management emphasis. [1]Minimum purchase accepted: $10,000. [2]Redemption charge. [3]No charge on shares held over three years. [4]Company suspended new share sales in 1944. [5]Open market price; 1948 year-end asset value: $42. [6]Dividends discontinued until capital deficit is made good. [7]1940-48. [8]1943-48. [9]1939-48. [10]1938-48. [11]1941-48. [12]1940-48. [13]1940-48. [14]1941-48. [15]1946-48. [16]1941-48. [17]1938-48. [18]Lightens or extends common stock holdings according to management's view of future market action.

* HANDITIP *

Musical Muffler

Without extensive soundproofing, it's sometimes hard to keep waiting patients from overhearing snatches of your consultation-room conversations. One simple preventive is soft music in the reception room. A radio or record-player, controlled from your inner office and wired to a small amplifier outside, does the trick.

* * * * *

character of each fund. Note that they are generally higher for the common stock funds than for the balanced funds. They show to what extent the prices of individual trust shares outran (if the index figure is more than 100) or lagged behind (if less than 100) the Dow-Jones industrial average during the stock market's ups and downs in 1948.

Management Expense. The bigger the trust, the cheaper it is, relatively, to manage. The behemoth Massachusetts Investors Trust, for instance, boasts the lowest ratio of operating expenses to assets; while the only funds with expenses last year exceeding 1 per cent of year-end assets were three comparatively small ones. Expense-ratio figures should be compared, of course, only among trusts of like size and aims. For a hint on how much a trust is earning, beyond its keep, weigh the expense index against income and performance figures in the next two columns.

Income Return. Investment trust dividends are of two kinds: (1) those paid from the interest and dividend income the trust receives on its security holdings; and (2) those paid from net profits realized by the trust on the sale of security holdings. Dividend payments from the latter source are not really income at all (the trust shareholder should consider them capital gains and pay the capital gains tax rate on them); for this reason they are not reflected in the figures of this column, which are *true income* percentages.

Take note that the income return figures are for one year only. In every case, except National Securities Income Series, a ten-year review of income shows a lower average annual rate than that of the single year 1948.

Profit Record

Performance. These figures are the most important—yet the trickiest—in the table. They show how much a shareholder would have made on his investment had he bought at the beginning of 1937 and held for twelve years, reinvesting all dividends from both income and capital gains. If you had put $10,000 into Fundamental Investors in 1937, for instance, your kitty by the end of last year would have grown to $19,700—a 97 per cent gain.

Average gain for all twenty-nine

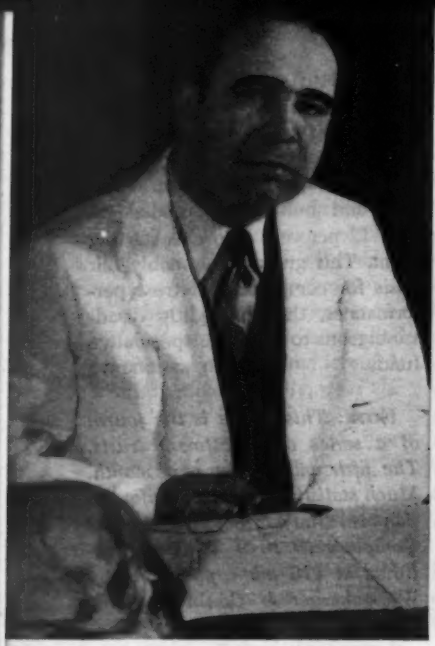
funds in the table was 58 per cent. This barely tops a 57 per cent bulge for the stock market at large (Standard & Poor's ninety-stock index), again with reinvestment of dividends. But doing as well as the stock-market averages over the long run is a feat few investors achieve. A better gauge of investment trust performance for the doctor-investor is his own record over a like period.

Twelve-year performance figures are not given for some trusts in the table, usually because radical policy changes have made them meaningless. The generally better showing of these trusts over a shorter span is no reflection on the other trusts; records of the latter improve, too, if the time period is shortened to start at a later date and, consequently, at lower market levels than those of early 1937. The 1937-48 period was selected because the stock market, after major bear and bull swings, ended up only 12 per cent below its starting point. This gives a reasonably fair basis for comparison of trust performances, though slightly disadvantageous to the more speculative funds.

—H. D. STEINMETZ

NOTE: *This article is the fourth of a series on investment trusts. The fifth will appear next month. Much statistical and other information is drawn from "Investment Companies," 1949 edition, published at $15 per copy by Arthur Wiesenberger & Co., New York.*

"So far I figure she's cost us $13.60 a pound."



Two spokesmen of organized Negro medicine: ◀ Prolific writer Dr. W. Montague Cobb edits the Journal NMA. ▼ Dr. C. Herbert Marshall is president of the association. Both favor the Truman health plan.

The Facts on Negro Physicians

A panoramic view of the profession's Negro minority and the problems it faces

● When Dr. Peter M. Murray takes his seat in the AMA House of Delegates next June, he will be the first Negro so honored in the association's 103-year history. Grandson of a slave, Dr. Murray worked as a night watchman to put himself through medical school. Today the 61-year-old physician is director of gynecology at New York's Harlem Hospital, a diplomate of the American Board of Obstetrics and Gynecology, and a fellow of the American College of Surgeons. For the past twelve years he has served in the House of Delegates of the Medical Society of the State of New York.

Critics of organized medicine dismiss Dr. Murray's AMA election

as window dressing. But many of the country's 3,700 Negro physicians hail it as another milestone in their progress.

Accredited Negro M.D.'s have practiced in the U.S. in appreciable numbers since before the Civil War. Their history dates back to the late 1700's, when Dr. James Derham, first regularly recognized Negro physician, built a substantial practice in New Orleans. Up until the first World War, the number of Negro practitioners increased steadily. But since then, deaths and retirements have about equaled new entries into the field.

The Case in Statistics

Here, in summary, is the status of Negro doctors today:

¶ They represent less than 2 per cent of the nation's doctors, although 10 per cent of the population are Negroes. There is one colored physician for every 3,800 Negroes, as contrasted with one white practitioner for every 750 white people.

¶ About 43 per cent of the country's colored physicians practice in the South, where the Negro doctor-patient ratio is one to 6,000.

¶ The vast majority are G.P.'s. Only one out of thirty-five is a certified specialist. (In the medical profession at large, one out of every nine practitioners is a board diplomate.)

¶ Negro M.D.'s have published some 2,300 scientific articles. About half these papers have ap-

New AMA delegate Peter M. Murray poses with friend. A past-president of the NMA, Dr. Murray is an outspoken opponent of compulsory health insurance, thinks it would hurt quality of medical care.

peared in the Journal of the National Medical Association.

¶ Only about 300 Negroes are believed to belong to the AMA. In seventeen southern states and in the District of Columbia, they are barred by local medical societies. Southern Negro physicans are thus automatically ineligible for many hospital posts.

This point became a hot issue at the AMA convention in 1948. Delegates from New York pressed for a constitutional amendment to prevent county societies from excluding qualified physicians because of race, creed, or color. The AMA House of Delegates decided, as it had before, that it could not interfere with the autonomy of local societies.

Back Door to the AMA

Some medical leaders have proposed a way around this impasse: The AMA could allow colored doctors to by-pass local units and join the association directly. But one Negro leader probably speaks for many when he says: "We would rather stay out than come in the back door. Besides, membership in a local society is an important part of belonging to the AMA."

Meanwhile, Negro physicians plug their cause through their own society, the National Medical Association. Its annual clinics are the only source of post-graduate education for many of its 2,000-plus members. It also gives support to Negro medical education, helps colored doctors get interneships and residencies.

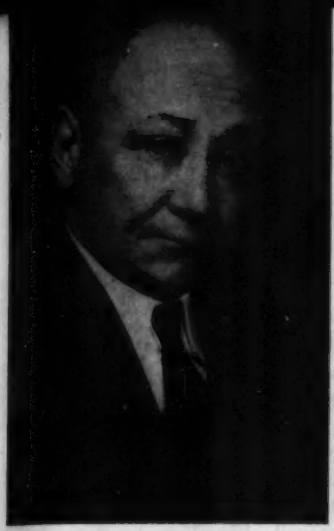
Founded in 1895, the NMA closely resembles the AMA in organizational set-up. Physicians qualify for membership by joining their county units. Delegates elected by constituent societies determine national policies, and a board of trustees carries out these decisions. As yet, however, the NMA has no permanent headquarters or salaried officials.

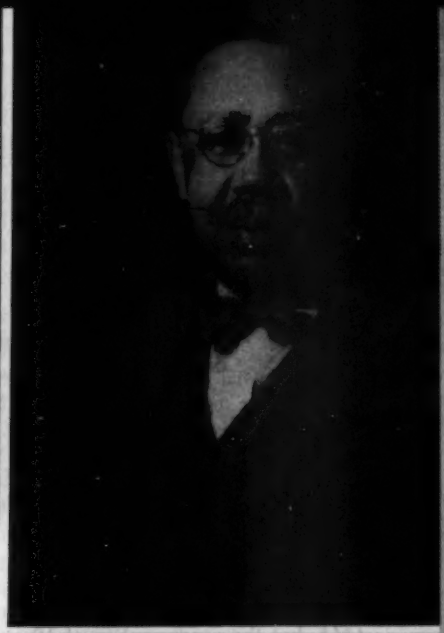
Deficit for the Journal

The 40-year-old Journal of the NMA, a bi-monthly, averages ninety-odd pages of scientific and advertising matter per issue. Unlike the Journal AMA, which turns a comfortable profit, it has never managed to get out of the red. A founder and long-time editor was Dr. John Andrew Kenney, new editor emeritus. Dr. W. Montague Cobb, prominent Negro educator, took over the editorship this year, succeeding Dr. Ulysses G. Dailey.

Though the NMA sets ethical standards for its members, in many instances it lacks the police power to enforce them rigidly. Dropping a physician from its roster carries few of the implications of similar action by the AMA. For example, when one Southern Negro doctor's picture and endorsement appeared on the wrapper of a well-known brand of bread, members could do little but throw up their hands in horror.

Like any other professional





TOP-RANK Negro physicians: Louis T. Wright (above) is chief of surgery at Harlem Hospital (N.Y.), where he and colleagues were first to treat humans with aureomycin. Author of some fifty scientific articles, Dr. Wright wrote chapter on skull fractures in Scudder's textbook of surgery. William A. Hinton (upper right) devised standard test for the detection of syphilis. First Negro to graduate from Harvard Medical School, Dr. Hinton is now clinical professor of bacteriology and immunology there. Charles R. Drew (lower right), one-time All-American halfback, won the Springarn Medal for his blood plasma work during war. Dr. Drew heads the department of surgery at Howard University and is also medical director of Freedmen's Hospital.

group, the NMA has its internal squabbles. Officers have been accused of "administrative bungling." Member societies have criticized "the consummately inefficient manner" in which meetings are conducted. The Detroit convention last August underscored the division among members on the issue of compulsory health insurance.

Boost for Truman

The National Association for the Advancement of Colored People has long been on record in favor of the Truman health plan. At Detroit, officers of the NMA urged the NMA delegates to follow suit. Said incoming president Dr. C. Herbert Marshall: "If you support the stand against Truman, you will receive a pat on the back from the AMA, but the condemnation of 10 million Negroes and the NAACP."

The convention postponed action. An informal canvass of the rank and file, it developed, had revealed a thumping majority opposed to compulsory health insurance. As leader of this opposition group, newly-elected AMA delegate Peter Murray pushed for a showdown; but the Marshall bloc managed to pigeonhole the issue.

Gaunt, plain-spoken C. Herbert Marshall, NMA president, is a general practitioner in Washington, D.C. He became a member of the association twenty years ago, soon after he was denied admission to the local AMA constituent society. His credo: "The only way you can accomplish some things is by agitation." He made headlines recently by accusing the AMA of "Ku-Klux tactics" against Negro doctors. The Truman program is, in his judgment, a "rebellion of the laity against the high costs of medical care"— a rebellion in which he's quite willing to carry a spear.

A good number of Dr. Marshall's NMA colleagues disagree with his views and methods—but none with his concern for the problems of the Negro doctor and his patients.

During the past eight years, the Negro population has increased by about a million; in the same period, the number of Negro doctors has actually dwindled a bit. If the supply of physicians is to keep up with population, says the NMA, medical-school enrollment of Negroes must be quadrupled.

Almost 85 per cent of all U.S. Negro medical men graduate from Howard University Medical School (Washington, D.C.) or from Meharry Medical College (Nashville, Tenn.). Each turns out from fifty to seventy M.D.'s annually. A score or so Negroes receive degrees yearly from about thirty-five other medical schools.

Knock for Colleges

Since both Howard and Meharry are operating at full capacity, any increase in the enrollment of Negro students will probably have to take place elsewhere. Negro educators say that twenty "white" schools bar colored students altogether,

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1. Biskind, M. S. and Biskind, G. R.: Endocrinology, **31**:109-114 (July) 1942.
2. Ashworth, J. and Sutton, D. C.: Arch. Int. Med., **69**:15-22 (Jan.) 1942.

THE E. L. PATCH COMPANY **Stoneham, Mass.**

that most others strictly limit admissions. The schools reply that few Negro applicants meet their qualifications. Some institutions, however, seem to come across more qualified applicants than others. The University of Michigan College of Medicine, for instance, has had up to eighteen Negroes enrolled at one time.

Residency Problem

Once out of medical school, the colored doctor finds little difficulty in locating an interneship. But later, if he decides to specialize, he is hard put to track down a residency. About two-thirds of these are to be found in four Negro hospitals: Freedmen's (Washington, D.C.), Homer Phillips (St. Louis), Provident (Chicago), and Hubbard (Nashville). Four smaller Negro institutions provide most of the remainder. Of 9,000 residents in white hospitals, only a dozen or so are Negroes.

For the average colored G.P., perhaps the most serious handicap stems from a lack of hospital facilities. Most voluntary and many government institutions do not give privileges to Negro physicians. Many men are thus denied much-needed clinical experience. Some Negro doctors operate makeshift hospitals in their homes. Of the nation's 120 Negro hospitals, nearly all verge on bankruptcy.

A few cities—notably Cleveland, Jersey City, Los Angeles, and New York—do better than others in giving Negroes representation on hospital staffs. Of New York City's 225 Negro physicians, 60 per cent now hold staff appointments in a total of thirty-two local institutions. One city hospital in Manhattan—Sydenham—has been operating on an inter-racial basis for six years. White and Negro doctors have worked together with practically no friction. In only a few instances have white patients caviled at being treated by a colored physician.

One objector was the father of a child patient. Hospital authorities said they could assign a white physician, but warned that the change-over might hinder recovery. The father relented. Informed of the incident, the Negro doctor stayed with the patient for thirty-six straight hours, refusing relief and having his meals sent in. The child recovered, and the M.D. won the profuse gratitude of the father.

One Man's Solution

How many Negro practitioners have crossed the color line by passing as white is, of course, unknown. But the number may be more substantial than is generally believed. Dr. Albert C. Johnston and his family did this for twenty years before letting their Keene (N.H.) neighbors in on their secret in 1948. "Lost Boundaries," a recent book and motion picture, dramatizes their story.

Many Negro practitioners across the country are breaking down racial barriers without resorting to

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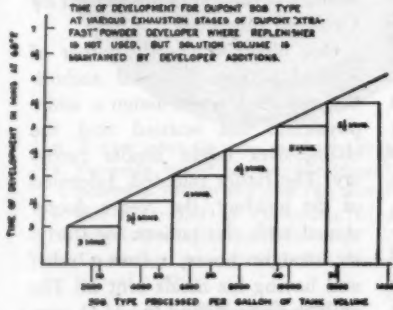

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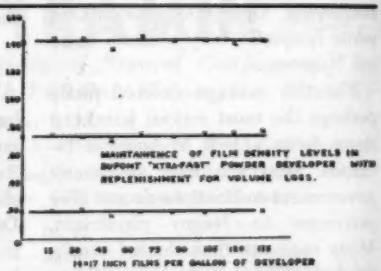

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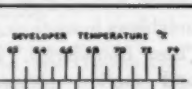

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such subterfuges. Two examples:

¶ Dr. L. Greeley Brown of Elizabeth, N.J., whose mixed practice got its start in the 1918 flu epidemic. He made up to 100 calls a day, later kept many of these emergency white patients as regulars, now treats as many whites as he does colored.

Serving as a delegate to his state AMA constituent society and a staff member of two local hospitals, Dr. Brown recalls that things were not always so rosy. Says the kindly, soft-spoken G.P.: "At one time, when prospective patients used to inquire where my office was, some neighbors would tell them I had moved away or had died. Now, an era of good feeling prevails. It's up to us to capitalize on it and expand it."

¶ Dr. Joseph B. Gilbert of Royston, Ga., who treated his first white patient (a pneumonia case) in 1937. Although the relationship between a Negro doctor and white Georgians was a bit awkward at first, Dr. Gilbert has since expanded his mixed practice, has delivered a number of white babies.

Prejudice Dying

Medicine's color line has faded perceptibly since the war. Many white-Negro friendships among medical men developed in military service. A number of colored practitioners back in civilian life report new indications of good-will from white colleagues. Other recent straws in the wind:

¶ A willingness evidenced by some medical schools—such as Washington University, St. Louis University, the University of Texas, and the University of West Virginia—to admit Negro students for the first time.

¶ An invitation to attend the AMA's mid-winter clinical sessions, extended for the first time to Negro members of the NMA.

¶ Admission of nearly forty Negro fellows by the American College of Surgeons during the past four years. Previously, the college had been accused of racial discrimination.

¶ Some 150 prospective staff openings for Negro physicians at a $2 million hospital under construction at Florida A & M College.

Negro M.D.'s Future

A number of Negro physicians point to these signs as indications that patience and perseverance are paying off. Others look for what they think is a quicker solution in the Truman health program. A few listen hopefully to the glittering promises of various fringe groups.

But nearly all recognize one fact: In the light of outstanding achievement—such as the work done by Dr. William A. Hinton of Boston, Dr. Louis T. Wright of New York, and Dr. Charles R. Drew of Washington, D.C.—prejudice among fellow practitioners melts like snow under a warm spring sun.

—ROGER MENGES

Pay balance due on your estimated tax for 1949. If end-of-the-year tallies have shown your previous estimates to be incorrect, file an amended estimate to avoid possible penalty. Or, if you wish, file your final return for 1949 and pay the balance due as shown thereon.	**Jan. 15**
File Form W-1 showing taxes withheld from your employes during the last quarter of 1949; pay amount shown thereon. File Form SS-1a showing old-age benefit deductions for the last quarter of 1949; pay amount shown thereon. Furnish your employes with original and duplicate copies of receipts (Form W-2) for all taxes withheld from their 1949 pay. Send in additional copy of each Form W-2, with annual reconciliation form (W-3).	**Jan. 31**
File information returns (Forms 1096 and 1099) for certain 1949 payments to individuals for interest, rent, salaries, etc. To be reportable, such payments must exceed $600, must not have been reported on Form W-2, and must not have been made to real estate brokers.	**Feb. 15**
File your final return for 1949 if you haven't done so already, and pay the ballance due as shown thereon. File your declaration of estimated tax for 1950 and pay one-fourth the total estimated tax.	**Mar. 15**

Timetable

Apr. 30 — File new Form 941 showing taxes withheld from your employes during the first quarter of 1950; pay amount shown thereon. On the same form indicate old-age benefit deductions for the first quarter of 1950; pay amount shown.

June 15 — Pay second quarterly installment of your estimated 1950 tax. Or file an amended declaration and pay one-third of the balance due as shown thereon.

July 31 — File new Form 941 showing taxes withheld from your employes during the second quarter of 1950; pay amount shown thereon. On the same form indicate old-age benefit deductions for the second quarter of 1950; pay amount shown thereon.

Sept. 15 — Pay third quarterly installment of your estimated 1950 tax. Or file an amended declaration and pay one-half the balance due as shown thereon.

Oct. 31 — File new Form 941 showing taxes withheld from your employes during the third quarter of 1950; pay amount shown thereon. On the same form indicate old-age benefit deductions for third quarter of 1950; pay amount shown thereon.

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The AMA Meets the Press

Question-and-answer sessions with newsmen provide some brisk and revealing exchanges

• Medicine's leaders have, in recent months, met some of their severest critics head-on. In Washington, D.C., and in New York City,* AMA officers have had top newsmen fire questions at them by the hour. Out of these conferences, staged as part of the AMA's National Education Campaign, have come some provocative new sidelights on the doctors' fight against compulsory health insurance.

Printed below are condensed excerpts from the verbal give-and-take. Among the AMA people quoted are Dr. Ernest E. Irons, Dr. Louis H. Bauer, Dr. George F. Lull, Dr. John Cline, Clem Whitaker, and Leone Baxter. Newsmen whose questions touched off the debate include Harold Goldsmith, William Mylander, Lester Grant, George Scullin, Joseph C. Harsch, Nathan Robertson, and Merryle S. Rukeyser.

• • •

DR. IRONS: The ethical medical men of this nation have not in the past devoted themselves to public relations—nor, unfortunately, to press relations. Their devotion has been to medical problems, to science, to research, to improving medical care, to curing the patient.

We have reached the conclusion that such a conservative policy is untenable in light of the attacks being made today on the American medical system. We have listened long enough to accusations against the principles and ethics of the American Medical Association and of its representatives.

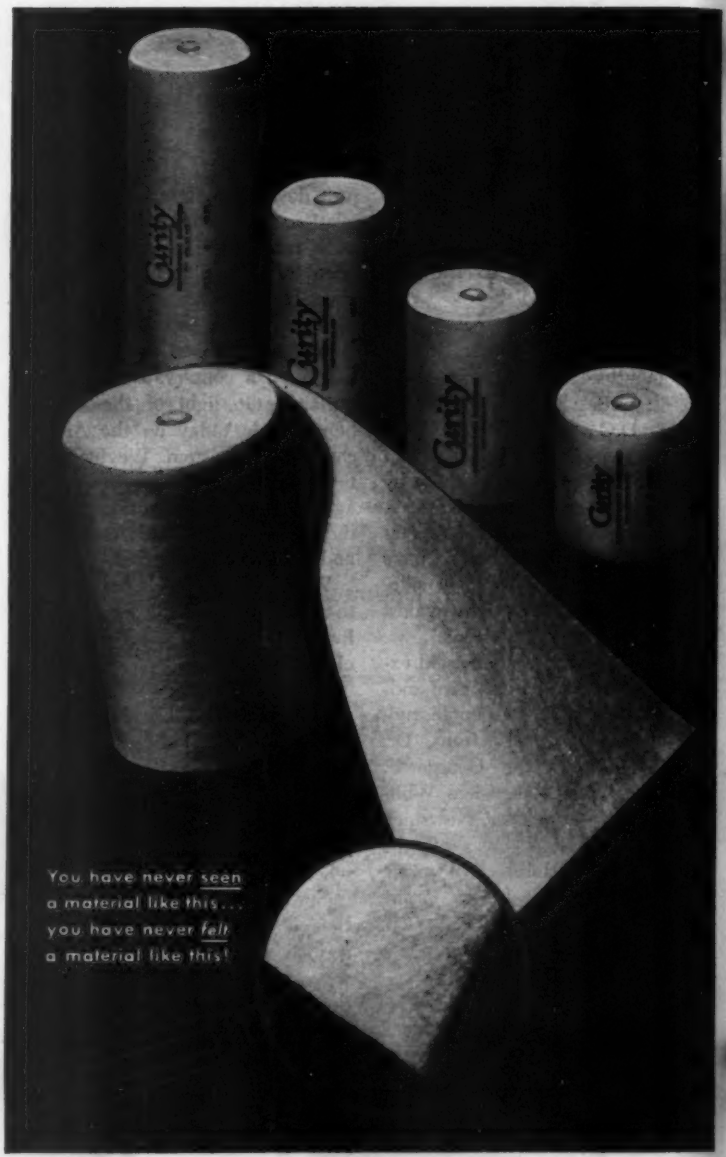
We feel the time is here for us to speak out the truth as we know it. That is the reason for this series of conferences.

• • •

DR. BAUER: If I had to give a brief definition of socialized medicine, I would say that it is any plan where the financial support comes from taxation by the Government, either direct or indirect; where the rules and regulations under which doctors, hospitals, and the public may take part are prescribed by the Government; and where the fees for services rendered are determined, either directly or indirectly, by the Government. That is socialized medicine.

[*Turn the page*]

*Future bookings: Chicago, New Orleans.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GOLDSMITH: What I want to know is this: At what point is the American Medical Association going to come up with a constructive program to correct national health deficiencies, instead of being anti-everything?

DR. LULL: That is a fine myth that has been repeated too often. I don't believe that you can tell me very many things the American Medical Association is against, except compulsory health insurance. We have approved the Hill-Burton Act for the extension of hospitals. We have approved in principle the bill for Federal aid to local health units. We have approved and appeared for Federal aid to medical education. We have approved the National Research Foundation. We have approved the World Health Organization. We *are* opposed to compulsory sickness insurance, and maybe there isn't any legislation that will correct that. The voluntary sickness insurance plans, as you know, are doing a terrific job.

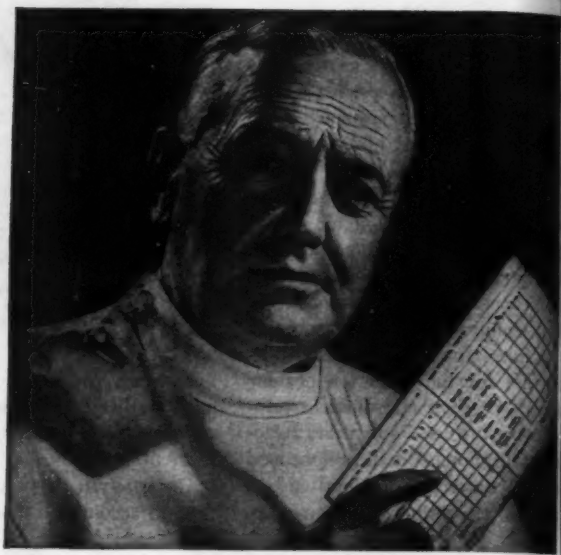
GOLDSMITH: But the average person in the low-income group cannot join Blue Shield. He can't afford it.

DR. CLINE: You say people can't afford it. People spend more for alcohol; they spend almost as much for tobacco; they spend more for amusements then they do for medical care under the current set-up. It is a matter of educating people, rather than a matter of compelling them. It's a matter of educating

them to give priority to their health needs rather than to do the things which provide them transient enjoyment.

GOLDSMITH: How do you propose to accomplish that?

BAXTER: When the AMA campaign began, at the first of the year, there were 52 million people covered by voluntary health insurance. At least 50 per cent of the doctors' campaign has been devoted to the constructive phase of building voluntary health insurance. Now, the doctors cannot launch a plan and simply say, "All right, this is what we are going to do." Any politician can outpromise a doctor. The doctor-sponsored medical care plan must be based on sound actuarial figures. It has to work. That soundly based plans *are* working under the voluntary system is proved by the record. Two days ago, the Health Insurance Council announced the latest figures. The coverage of the voluntary plans is now 60,955,000. That



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• • •

MYLANDER: But this voluntary health insurance really does not get at the seat of the problem, does it? What about the people who are too poor to look after themselves—what Senator Taft calls the 15 or 20 per cent of the people? What is the AMA's answer to that?

DR. CLINE: I think that neither Senator Taft nor anybody else knows as yet exactly what the problem is. You have to take into account the many different geographical and political divisions of the country. The problem is not the same in one place as it is in another. We look upon the care of the indigent as being primarily a local responsibility. But when the local community does not fulfill its responsibility, then the state has a reasonable interest. When the state does not fulfill its responsibility, then the Federal Government should become interested. But Federal intervention in that type of program ought to be limited to cases where there's been demonstration of actual need within the state. Until we have information showing that need, legislation designed toward that end is premature.

MYLANDER: But how long do you think the patience of the people is going to endure? When I, for example, am called on to pay $200

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for an appendicitis operation, the excuse is that I can pay it and that the doctor is performing a lot of other operations for charity . . . Wouldn't you say $200 is pretty steep for an ordinary appendix?

DR. CLINE: I think it depends upon the circumstances of the individual.

MYLANDER: That is, the ability to pay for it, as used by the doctor in figuring his fee?

DR. CLINE: Do you see that as objectionable?

MYLANDER: Yes.

DR. CLINE: Well, then, you have the opportunity to insure yourself. I should think that you would avail yourself of that opportunity.

MYLANDER: I don't know of any insurance plan that would cover it.

WHITAKER: There are many private insurance plans that will insure you for any surgery.

DR. LULL: You can get complete coverage for everything, if you want to pay for it.

• • •

DR. BAUER: The American Medical Association was always roundly damned because it opposed voluntary insurance when it was first proposed. Personally, I think it was the smartest thing the association ever did. Because if it hadn't, there would be no voluntary insurance today.

When voluntary insurance was first proposed, there was no such thing in this country. The only examples we had were plans existing in Europe, which were not good. They didn't give good medical care. After a year, the association did approve experimentation to see what could be developed. There must have been 300 plans that grew up then around the United States. Most of them folded up because of the very thing the American Medical Association had said about them. They were not actuarially sound, they didn't deliver good medical care, and the public was being gypped.

As a result of all this experimentation, four different types of plans finally developed. One was for hospitalization; one was for surgery and obstetrics; one was for that, plus in-hospital medical care; and the fourth was for complete medical care. Since then it has been, some insurance people say, the fastest-growing insurance project in the history of the country.

Three things have yet got to be developed: (1) We have got to be able to enroll individuals as well as groups. That is now being worked

out, and some states are already doing it. (2) We also have to protect the older individuals, because many of these plans will not take a person after he is 65 and some of them have actually dropped them at 65. (3) We must also develop a policy that will allow additional benefits if the persons want to pay for them. These things are being worked out gradually. Remember that this is a young game yet, and we are nowhere near the complete answer.

• • •

GRANT: What are you proposing to do to enable the people not covered now to get that coverage?

DR. BAUER: These plans are still growing. I think probably that 80 to 90 million people will eventually be covered through voluntary insurance plans. Bear in mind there are some 24 million people in the country who get their care in whole or in part from the government. There are some 10 million who do not care what medical care costs. There are about 5 million indigent. Another 10 million—including those who don't believe in medical care—get taken care of through various other methods. For example, we have our friends the Christian Scientists, who don't care to employ a doctor. That is their right. We also have people who prefer to buy their medical care over a drugstore counter.

When you add all those figures together, you have an enrollment potential somewhere between 80 and 100 million, which I think we will be able to attain in the next two or three years. We will then—with all the other groups—have all of our population covered who want to be covered.

• • •

SCULLIN: It has been said here today that one of the smartest things the American Medical As-

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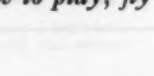

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sociation ever did was to oppose the early voluntary plans, because that subjected them to a kind of scientific screening. I wonder if we are to assume that doctors are opposing the present Government health plan with the idea that they will eventually approve it.

DR. BAUER: We certainly are *not* looking on compulsory health insurance with a jaundiced eye because we think later on we might approve it. We already have plenty of examples in other countries of compulsory health insurance. We know how that works elsewhere.

* * *

GRANT: How many members of the American Medical Association have so far turned in the $25 assessment?

DR. LULL: We have collected 60 per cent in our office. Some of the money is still in the states; they haven't sent it in yet. But 60 per cent of the total membership have paid. That's a total of a little over $2 million. We hope to get several hundred thousand dollars more.

Cost of a Lobby

WHITAKER: Undoubtedly you are all familiar with the charges that the American Medical Association has a $3,500,000 lobby. The charge that the money is being spent on lobbying is inaccurate in itself. We have in Washington, so far as lobbies are concerned, one man who gets a salary of $12,000 a year and whose expenses for the year will probably not exceed $1,500. He is there as a press representative and as an observer. We have no high-pressure lobby.

* * *

HARSCH: How much substance is there in the charges that the AMA or its representatives have been engaged in trying to buy newpaper influence, or in putting undue pressure on them?

WHITAKER: That charge is absolutely false. There is not one iota of truth in it. Certainly the American Medical Association is not engaged in buying the press.

ROBERTSON: You do not deny there was one case of an editor and publisher being bribed? I am talking about the cartoon contest.

DR. CLINE: I do deny unequivocably that that was an effort by the medical profession as such. That brings up the late and unlamented National Physicians Committee. Is that what you are talking about?

ROBERTSON: Yes.

DR. CLINE: There used to be a foolish attitude that American medicine should be purely a scientific assembly. The problems confronting American medicine are such that it should always have been a business league. Certain people desiring to keep the American Medical Association a scientific assembly set up a National Physicians Committee. When it was originally set up, the board of directors consisted very largely of officers of the association. It was thought thereby that the American Medical Association would be able to control the

National Physicians Committee.

It was quite apparent to me, as it was to many other doctors throughout the country, that the programs and policies of the National Physicians Committee were not practices that we wished to espouse. Gradually, more and more, it went to an extremist point. Toward the end, there was not a single officer of the American Medical Association who remained on its board of trustees. I think—maybe I am not justified in stating this as positively known—but I think it became the tool of certain laymen who were running it. Ultimately it reached the point where the AMA had to repudiate it. When medical support was withdrawn, it died.

• • •

RUKEYSER: It seems to me that a lot of the campaigning and questions have created a false frame of reference. I don't think it is up to the American Medical Association to prove that our medical care is either perfect or complete. In free enterprise, there is always room for tremendous improvement. I think the American Medical Association should be the first to say that. I don't know why in the campaign you don't stick to the simple facts. I think you ought to concentrate on demonstrating that the Murray-Dingell bill is Blue Sky, and that there aren't the personnel or facilities available to carry it out even if it were desired.

WHITAKER: That is exactly the gospel we want to get over and have been trying to get over. END

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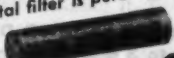

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Introductory Offer to Physicians—Write for Denicotea holder. $1. postpaid (regular price $2). Lady Denicotea $1.75 (regularly $3.50). Alfred Dunhill, Dept. E, 660 Fifth Ave., New York 19.

Doctors' War Role Debated Anew

Congress sifts issues in civil defense wrangle, may clarify medicine's position

• If an atomic bomb exploded over your city tomorrow, what would be your role in meeting the disaster? More important, what would be the role of medicine at large in the event of an attack on many U. S. cities at once?

Last month neither the Government nor the medical profession knew the answer. But the Joint Congressional Committee on Atomic Energy had set about finding it, pronto. Russia's development of the A-bomb, three years ahead of Defense Department estimates, had suddenly brought much nearer the day when our one "potential enemy" will have a war-sized stockpile of such weapons.

The nation's civil defense plans, as shapeless as a deflated football, have been kicking around Washington for two years. In 1947 the Defense Department set up a special division, headed by Nebraska utility executive Russell J. Hopley, to study the problem. The Hopley report, with its medical defense plans fashioned by Johns Hopkins internist Perrin H. Long, was completed in the summer of 1948.

It mapped out a detailed blueprint for civil defense mobilization. It urged the creation of a permanent Office of Civil Defense, within the Defense Department. The Hoover Commission thought that the proposed OCD should be under the National Security Resources Board, but otherwise endorsed the Hopley report.

A number of Government agencies lined up against it, however, fearing infringement of their own functions by the new civil defense office. Walter Winchell hissed that it was all a Forrestal plot to impose a police state on the nation in time of war.

Defense Split Up

Early in 1949, President Truman transferred the responsibility for leadership in civil defense planning to the National Security Resources Board. But he declined to set up a permanent civil defense office. Activities that were to have been centralized in such an office were parceled out to other agencies. The master plan drawn up by the Hopley group was shelved.

This fall, Russia's A-bomb blasted the whole question wide open

again. Members of Congress, fense Department officials, Cross executives, and many doc believe that the Truman action hamstrung civil defense prep tions. The National Security sources Board retorts that eve thing is being done that can done.

To date, this has consisted encouraging state and local gove ments to set up their own civil fense agencies. The NSRB is nishing them with some infor tion and guidance. So far, thir states have passed civil-defe laws. Some forty state Gover have appointed defense direct with widely varying powers and sponsibilities. A few cities are for ing rudimentary defense organiza tions.

Too Few Safeguards

This, say critics, is not enough. They point to lack of provision f mutual aid among stricken co munities, or for authoritative gional control. They deplore t kowtowing to states' rights in t face of a national disaster proble They seek creation of a Fede civil defense office by Congr sional action. Their campaign currently being carried on in t atomic energy committee on C tol Hill.

Meanwhile, as the problem thrashed out once more, these g facts remain:

One A-bomb dropped on one ures, would result in 100,000 ca

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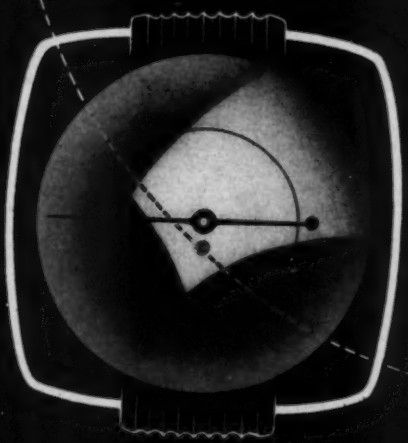

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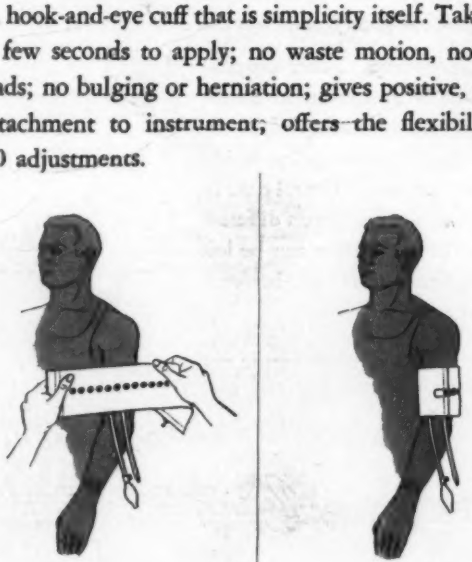

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alties. Of these, 40,000 would be fatalities.

The remaining 60,000 would need varying degrees of care during the first three weeks after the blast.

Atom Blast Staff

To handle such a holocaust, 5,000 physicians (60 per cent of them specialists) and 60,000 supporting personnel would be needed, Dr. Perrin Long believes. Three hundred first-aid teams, 500 stretcher-bearer teams, 400 casualty collection points, and 40 neuropsychiatric centers would be required in the first twenty-four hours.

Multiply these figures by ten or twenty, the number of cities that might be hit simultaneously, and you get a rough idea of the magnitude of the problem. Since nearly every doctor in the country might have to turn to in such an emergency, some sort of *national* planning seems in the cards.

—J. F. MARTIN

Anecdotes

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Interest Payments as Tax Deductions

What interest outlays you may—and may not—deduct in filing your Federal return

• Don't feel too blue any time you scribble out a check that includes a sum earmarked for interest. That sum may nearly always be used to whittle down the amount you owe the Federal income tax man next time he extends his palm.

Interest paid as part of your professional operating expenses counts, of course, as a "cost of doing business," and is deductible as such. Interest paid in many of your personal transactions is also deductible—provided you itemize your expenses instead of taking the standard deduction. Specifically, you may deduct all interest you were liable for—and actually paid in 1949—on these obligations:

Loans. It is immaterial whether the money was borrowed from a bank, from a finance company, or from an individual.

Mortgages. This includes mortgage interest on real estate now owned by you and on real estate formerly owned by you if, in the tax year, you were still liable on the mortgage bond and had to pay the interest. If you are personally liable on the mortgage of a corporation, you may deduct the interest you paid on that, too.

Installment purchases. If you bought an automobile, a household appliance, furniture, or anything else on a deferred payment basis, you may deduct interest charges included as part of your installment payments. To make such a deduction allowable, however, the interest part of the payments must be segregated from principal in your contract with the seller or in the actual payments. Deferred payment deals are variously set up as personal loans, conditional sales, bailment leases, chattel mortgages, or simple installment payments on account of unpaid balance. Unless the interest element can be definitely identified and separated it cannot be deducted on your Federal income tax return.

Notes. This includes interest on your own notes and on the notes of others for which you are legally liable, if you actually paid it. A

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* *Alfred J. Cronin, the author of this article, is a member of the staff of Murphy, Lanier & Quinn, accountants and tax consultants.*

common practice with banks and other lenders is to discount notes—that is, to deduct interest in advance. Thus, if you discounted a note for $1,000 at 6 per cent, you received $940. Only when you repay the $1,000 will you really pay the $60 interest; so you may not deduct it until you pay it.

Life insurance loans. Interest on such loans is deductible only if paid in cash. If the interest is added to the amount of the loan, it is *not* deductible.

Ordinary debts. Interest paid on any ordinary debt, even when the debt is not in writing, is deductible. In some states, judgments and open accounts bear interest at a specified legal rate; such interest is deductible when actually paid.

Family loans. Interest paid on loans from your wife or other members of your family is deductible if you can show the loan is a *bona fide* business proposition, not a gift.

Delinquent taxes. If the Government rules that you have not paid your full tax, you will be charged interest on the deficiency. You may deduct the interest from your gross income, but not the amount of the deficiency itself. A tax *penalty* is not deductible.

Non-Deductible Interest

There you have the chief types of deductible interest payments. There are also some non-deductible types. You may *not* deduct interest paid on:

Notes, mortgages, and similar obligations of others for which you had no legal liability. For example, if you paid your son's mortgage interest to save him from foreclosure, you may not deduct it. But if you owned the property—even if you were not directly liable on the bond or mortgage thereon—any interest you paid on the mortgage *would* be deductible.

Margin account with your broker, unless you paid it in cash or unless the broker collected dividends, interest, and proceeds of sales of securities out of which he took the interest due him.

Giving a note for interest or giving a note for the full amount of the debt plus interest is not considered payment. Interest in such transactions may not ordinarily be used as a deduction. —ALFRED J. CRONIN

* HANDITIP *

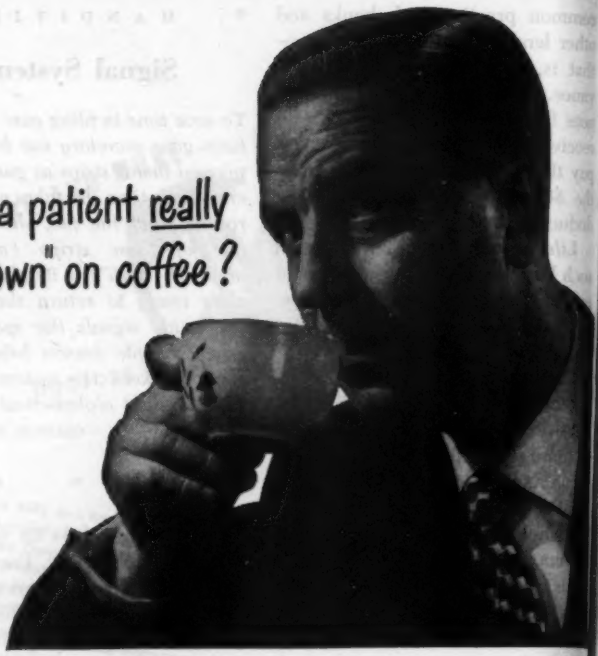
Signal System

To save time in filing case histories, have your secretary use bright red pressed-board strips as guide markers. Each time she takes a patient's record from the file, she can put one of these strips (measuring about 1¼ x 9½") in its place. When she's ready to return the history, the guide signals the spot. Even when the file drawer bristles with these markers, the system is faster than straight alphabetical location.

—GEORGE W. CONDIT

* * * * *

Will a patient really "cut down" on coffee?



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Because—for anyone who really loves coffee—cutting down on it is a very hard thing to do. There's always the awful temptation to have another cup...

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Patients can drink all the Sanka Coffee they want without the slightest question about caffein-effect.

We suggest that you try drinking Sanka yourself. We know you will appreciate what a fine coffee it is. And if *you* are affected by caffein—it may very well be the answer to your own problem, as well as that of your patients.

Sanka Coffee

The Perfect Coffee for the patient affected by caffein

Products of General Foods

Life Among the Doctors

Paul de Kruif's latest book, evaluated by Critic Isabel K. Brown

• With "Microbe Hunters," Paul de Kruif achieved renown as an outstanding popular writer on medical subjects. Here was an author who knew how to pack lively interest into scientific facts, to whom the slow but steady progress of healing—from the shaman's bag to the modern scientific laboratory—was touched with high dramatic excitement.

Later works from de Kruif's pen did not live up to the expectations created by "Microbe Hunters." At first an interested and reverent spectator at the drama of medicine, he tended more and more to project himself upon the stage, with extravagant praise or censure for the actors as they followed or opposed his views. Spotless "heroes" and deep-dyed "villains" supplanted the flesh-and-blood humans found in his first popularization of medicine.

In "Life Among the Doctors,"* the De Kruif pattern suffers from the law of diminishing returns. There is the same enthusiasm for the war against death, the same admiration for those who forge the weapons. But the "heroes" do not emerge as titanic, nor their martyrdom as convincing, as in his earlier books.

This is no reflection on the physicians portrayed. It is simply that the villainies de Kruif injects into each story are too contrived to carry conviction. No honest difference of opinion is accepted as such. Every obstacle is depicted as a Machiavellian plot, with the forces of evil variously represented as "medical leadership," government health services, medical schools and hospitals, and the "big-time operators" of the

*Life Among the Doctors. By Paul de Kruif. In collaboration with Rhea de Kruif. 470 pp. New York: Harcourt, Brace & Co. $4.75.

large health foundations.

Even the late President Roosevelt mutates from a "fighter for the lowly and forlorn" into "an unmitigated top man" when he gives precedence to military requirements over the health program advocated by de Kruif.

de Kruif vs. de Kruif

This constant grinding of the author's personal axes detracts from the story he sets out to tell. The accomplishments of Drs. Tom Spies, Herman Kabat, Leo Loewe, and the other protagonists of "Life Among the Doctors" need no backdrop of martyrdom to enhance them. What's more, the atmosphere of conspiracy and obstructionism created by de Kruif is at variance with facts he himself relates.

Dr. Spies, for example, received aid and recognition from the University of Cincinnati, which allowed him nine months out of each year to pursue his research; from a former president of the American Medical Association, who secured a hospital post for him with unlimited clinical material for the testing of his methods; from a foundation that gave him a "really big grant of research money"; from the American College of Physicians, which conferred its John Phillips Memorial Award upon him; from the Medical Association of the State of Alabama, which gave him a citation for his work; from the Southern Medical Association, which awarded him its gold medal; from his fellow physicians of Jefferson County, Ala., who presented him with a testimonial scroll; and from the AMA itself, which named him to its Council on Foods and Nutrition.

In the face of this record, it is not easy to make out a case for his crucifixion, by "medical leadership" or by anyone else.

The same is true of most other "hero-victims" portrayed by de Kruif. Leo Loewe, to cite another specific instance, was no "medical politician"—but his successful treatment of subacute bacterial endocarditis was first published in the Journal AMA. This will occasion no surprise among physicians. But let lay readers take note that the AMA, according to de Kruif, is the "doctors' union" and does not encourage treatment which might take "business" away from its members.

In almost every instance the bugaboo of greed, envy, and calumny that stalks through the pages of "Life Among the Doctors" dissolves on close examination. Perhaps physicians *are* overly slow to adopt new therapeutic methods. If so, the reason lies in the wait-and-see attitude inculcated by scientific training, and not in meretricious considerations of personal gain.

Undoubtedly the gap between discovery and application of new methods could be shortened if physicians were less insistent on thorough trial. Unfortunately, they have seen too many vaunted panaceas prove unsafe as well as ineffectual after the initial furor. More than

one measure heralded with ebullient enthusiasm by de Kruif has turned out to be a flash in the scientific pan.

The ambivalence in de Kruif's attitude toward medicine is evident throughout his latest book. While he is devoted to the healing art, he apparently cherishes a deep-seated grudge against its practitioners for not accepting him as a full professional partner. This leads him into flagrant distortions of motives.

In his account of Clifford C. Young's great fight to lower child mortality in Michigan, he actually suggests that physicians might not welcome a preventive for diphtheria because it would take away their "business of treating" it. Similar innuendoes are to be found on almost every page.

There are many indications that de Kruif's antagonism toward organized medicine stems from personal grievances. Witness his offers to help the AMA in its fight against socialized medicine since the deposition of Dr. Morris Fishbein. The long-standing feud between these two is no secret.

If de Kruif had charged the brilliant but often provoking editor of the JAMA with ultra-conservatism or with usurpation of authority beyond that of his official position, many doctors would have agreed. But to insinuate that he deliberately withheld support from, or sabotaged, therapeutic advances to further the financial interests of the profession, is a type of denigration

● Now, there is an effective ally against the disease known for its rasping difficulties.

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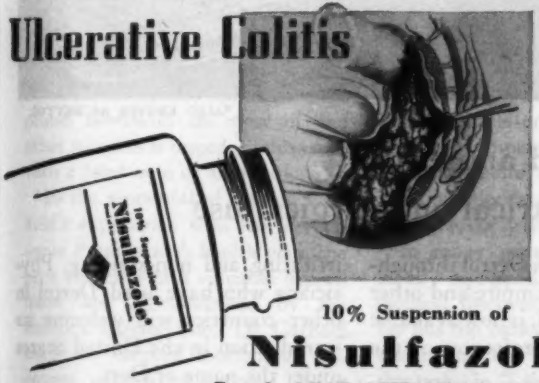
An Advance in the Therapy of Ulcerative Colitis



Full facts about Nisulfazole sent to physicians on request.

1. Major, Ralph H., Am. J. Med. 1:485 (Nov.) 1946.

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DETT *THE MODERN WEAPON AGAINST INFECTION*

that even Dr. Fishbein's sternest detractors must condemn.

Although there is little middle ground between sainthood and dastardliness in "Life Among the Doctors," a few of the characters emerge as real people—notably "Cy" Young, Herman Bundesen, and O. C. Wenger. The obvious relish de Kruif takes in their somewhat rough-and-tumble public health methods is communicated to the reader. While Dr. Bundesen's pioneering role in the treatment of syphilis is exaggerated, his accomplishments in the eradication of this and other infectious diseases in Chicago are vividly described.

The portrayal of Alvin F. Coburn does not come off so well. Encumbered with the title of "dreamy doctor" to start with, Dr. Coburn has the additional disadvantage of not pursuing to the utmost the particular line of research most favored by de Kruif. Hence the unqualified praise bestowed on most of the other subjects is tinged, in this case, with a faint note of admonition.

In the recountal of Sidney Garfield's experience with the Permanente Foundation's health plan, the pros and cons of a valuable experiment are overshadowed by the author's extreme bias. Dr. Garfield made no original, portentous discovery, as de Kruif suggests. What he did was to apply the principle of prepaid group practice to a mushrooming industrial community born of the war and lacking adequate facilities for medical care. That he supplied quantity service without appreciable sacrifice of standards is an accomplishment in itself.

There is not much doubt that group practice is the most efficient way of supplying extensive specialized services. But it is equally true that individual practice is a less costly way to treat the great majority of common ailments. While de Kruif repeatedly refers to 7-cents-a-day as the cost of full medical coverage under the Permanente Health Plan, his own figures show the average over-all cost for a family to be almost four times that amount—or about $100 a year.

He does not compare this figure with the rates of other prepay plans, notably those operated under the auspices of organized medicine.

In like manner, he glosses over other facts that might be considered unfavorable. He depicts Dr. Garfield as leaning over backwards to deal fairly with local colleagues. The extensive—and expensive—promotional campaign to win patients for Permanente at the expense of solo practitioners in Alameda County receives only the briefest mention.

In many respects, de Kruif is ideally equipped to expound new medical discoveries to the public. He has the background, the enthusiasm, and the literary ability for this task. In "Life Among the Doctors," these excellent attributes are vitiated by his absolute partisanship and by his unrestrained abuse of all who fail to share his allegiances. —ISABEL K. BROWN

Flowers Aren't Only for Anniversaries

Ever try them in your office? The idea is less frou-frou than you may think

• "Flowers in my reception room? What do you take this for—a gypsy tea room?"

That riposte probably sums up the attitude of many a medical man when floral decorations are suggested. But hold on a minute. As Osler might have said: Remember the patients. They're the ones your reception room is built to bulge with. And if flowers help to put them in a better frame of mind while they wait—well, what have you got to lose?

At all events, here's a boutonniere of suggestions from flower experts. They're practical in the extreme. And if the idea of turning floral designer still leaves you queasy, simply pass these tips along to your secretary. She'll probably delight in the details.

First question: What about cost? It varies widely, of course, but need not amount to much. One way to keep this a low-budget proposition is to arrange a by-the-month deal with a local florist. Many flower merchants are glad to unload some of their overstocked items every couple of days, and M.D.'s in a number of cities have standing orders of this kind. The plan seems to work out well—and economically.

Flowers fit in with almost any surroundings, so the selection of good color combinations isn't much of a job. Simply remember that you're trying to achieve *harmony* (with neighboring shades) or *contrast* (with complementary shades).

Inasmuch as flowers usually bulk small in a room, contrasting combinations are often the most effective. Thus: deep magenta tulips against a pale gray wall; misty blue delphiniums on a broad mahogany desk-top. The need for a proper setting can scarcely be over-emphasized. It will throw a flower arrangement into striking relief.

A Law for Arrangers

Whatever artistic errors the untrained male may commit, let him remember at least this one rule:

Don't stuff too many flowers into a single container! When you think you have about the right number, remove a third of them.

The next rule is that of proportion: A flower arrangement should be from one and a half to two

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*THE ORIGINAL PLANTAGO OVATA CONCENTRATE

times the height of a tall vase, or from one and a half to two times the width of a low bowl.

Balance is equally important. It usually means varying the stem lengths so that the large, dark flowers will be near the edge of the container; the small, lighter blossoms at the top. This allows the arrangement to settle down on a solid base. It also softens the hard line between the container and the flowers, allowing the two to combine more naturally.

One practitioner with an especially modern office solves the problem of stems by cutting them off entirely. In a large, low, crystal dish he floats a couple of stemless water lilies, or some baby gladioli, or a giant scarlet hibiscus.

The florist of today regards his flowers and their container as a unit. The purpose being, of course, to make one complement the other. He'll place bright Guinea Gold marigolds, for instance, in a crude Mexican pottery vase. Or fragile blue salvias in a container of fine Italian glass.

Props for Posies

To make flowers stand up in a shallow vase or bowl, a holder of some sort is essential. The kind you buy are usually made of glass or wire. If you want to improvise one, simply slice off a thick, flat chunk of apple or potato, poke a few holes in it, and insert the stems.

The old belief that aspirin will make flowers last longer has been rather thoroughly discredited. But almost any florist will supply you, on request, with a newer synthetic preservative. This is said to convince the cut flower that life is worth living after all.

If you're not inclined to treat

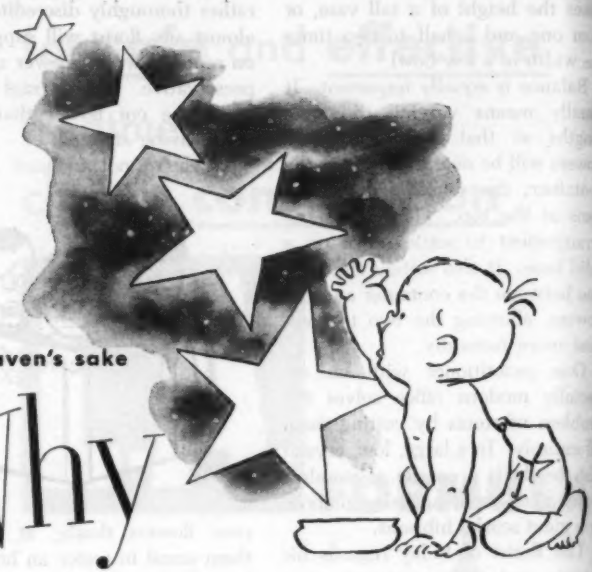
your flowers thusly, at least let them stand in water an hour or so before arranging them. Trim the stems slightly or split them an inch or so. This permits the water to rise more readily to the blossoms.

Leaves tend to rot quickly, giving off an odor that's bad enough in a home but intolerable in a medical office. So trim off any foliage below the water line.

A novel method of displaying flowers—particularly red roses—is to submerge them in a glass bowl that's filled to the top with water. Weight the blossoms with any small object that will sink. You'll probably like the result.

And if you don't you can always throw the roses out and get yourself a couple of congenial guppies.

—JAMES WILSON



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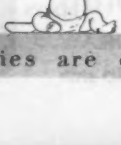

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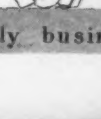

Babies are our business... our only business!

Where Health Insurance Stands Today

A frank report on successes —and failures—of existing plans, as seen by Paul Hawley

• Voluntary health insurance has not reduced, and cannot reduce, the cost of medical care. But it has gone a long way toward easing the burden of this cost—even though it still has a long way to go before it can boast of a task fully accomplished.

The most conservative estimates are that more than 60 million of our citizens are now protected to some degree against the cost of medical care. Of these, about 35 million are enrolled in Blue Cross. In addition to some 12 million Blue Shield subscribers who are also enrolled in Blue Cross, there are about 1 million who carry Blue Shield alone. This makes about 36 million different individuals who are enrolled in the voluntary, nonprofit plans. Some 25 million additional people carry commercial health insurance, are enrolled in local cooperatives, or are protected by employe benefit associations.

This year, Blue Cross will pay approximately $350 million to hospitals for the care of Blue Cross subscribers. This will represent between 80 to 85 per cent of their total hospital bills.

Blue Shield Shells Out

Blue Shield will pay approximately $100 million for the medical care of its 13 million subscribers. Dr. Frank Dickinson, the economist of the American Medical Association, estimates that this represents about 55 per cent of the total medical bill of Blue Shield subscribers. It is practically all for medical care in hospitals, since few Blue Shield plans cover home and office medical care.

This introduces the question of how much protection against the costs of medical care is justifiable on economic grounds.

Approximately half the total annual medical bill of the country is for hospitalized illness. This half is borne by 10 per cent of the population. The other half is spread among 90 per cent of the popula-

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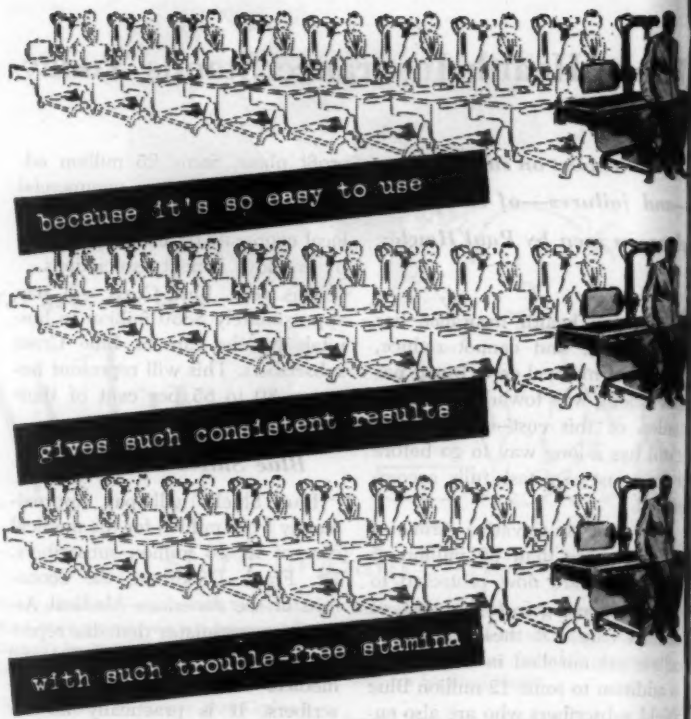
** This article approximates Dr. Paul R. Hawley's recent talk before the Association of Life Insurance Medical Directors, in New York. Dr. Hawley is the chief executive officer of Blue Cross-Blue Shield.*



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tion. Obviously, the small spread of the cost of hospitalized illness makes this part of the health bill a proper item for insurance. Through insurance, this half of the bill can be spread over ten times the number of people as would have to pay it were they not insured.

In this manner, the cost of hospitalized illness to the individual family can be reduced to a sum well within the budget of almost all self-supporting people. The cost of such protection for an entire family will not exceed $75 per year, which is approximately the cost of one package of cigarettes a day. There are few family budgets that will suffer from such a charge, especially when payments are made monthly.

The Uninsured Half

But what about insuring the other half of the medical care bill—the half that is paid for medical care *outside* of hospitals?

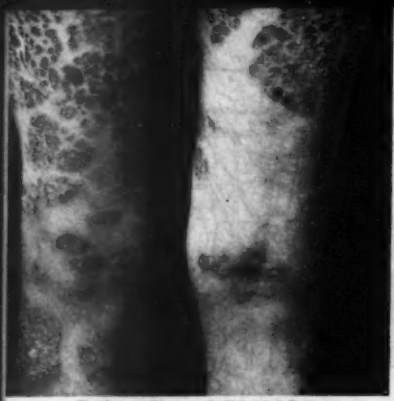
In instances where Blue Shield plans have experimented in covering home and office visits, it has been found that more than 50 per cent of these casual medical bills are for sums less than $6. The administrative cost of processing and settling such claims is around $3 per claim. This means that the insured person, in the aggregate, is paying at least 50 per cent more than, and often twice as much as, the service is worth.

Thus, we encounter the law of diminishing returns when we attempt to insure against the costs of small medical bills. The same situation would obtain in government compulsory insurance, thus greatly increasing the cost of medical care—a fact that is not often recognized.

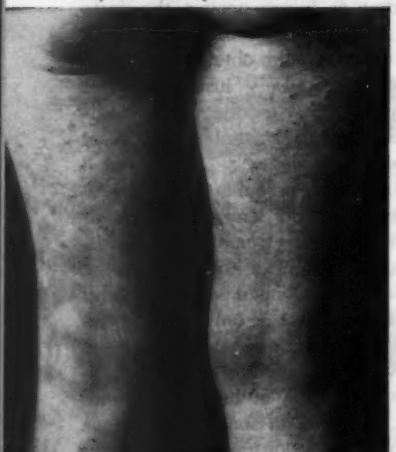
It is also probable that full protection would lead to abuses of the service by some people. This, too, would raise the cost of the protection. Remember that health insurance is the only kind of insurance that is not protected by law against abuses. Even the indemnity type of health insurance is protected to some degree by a dollar limitation upon benefits; but service plans are entirely at the mercy of the patient, the physician, and the hospital.

For these reasons, I am firmly of the opinion that, *at the present time at least*, it is neither feasible nor economical to extend the scope of protection much beyond the cost of hospitalized illness.

I think we may summarize the



Before Use of RIASOL



After Use of RIASOL

The $64 Question in PSORIASIS answer: RIASOL

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RIASOL FOR PSORIASIS

successes of voluntary health insurance as:

¶ A convincing demonstration that burdensome medical costs are insurable, at a rate within the reach of almost all self-supporting people.

¶ A steady growth of voluntary plans, so that now at least 40 per cent of our total population (and perhaps 50 per cent of our insurable population) are protected to some degree against the costs of health care.

¶ The provision of assured revenues to hospitals. These offset, to some degree, the diminishing returns from endowments and replace the sources of private philanthropy, which have largely been dried up by heavy taxation.

¶ A reduction in medical indigency. This has decreased the amount of charity work required of voluntary hospitals and has increased the self-respect of many families with marginal incomes.

Health Insurance Flops

So much for the successes. In my opinion, the *failures* are of far greater importance, especially at this time. First among these failures, I would list the failure to educate people that health insurance has become a necessity in perhaps 80 per cent of the families in this country.

Since the need for medical care crops up at irregular and unpredictable times, too few people even consider it in the preparation of the family budget. Furthermore, since both the amount of medical care required and its cost are as unpredictable as the date, it is impossible to budget for it upon a pay-as-you-go principle.

Educate the Masses

So people must be educated to the facts that (a) medical care is just as much a necessity as food, shelter, and clothing; and (b) its cost can be budgeted, but only in the form of insurance. While there is a slowly increasing realization of these facts, we have not moved fast enough in this direction.

Second, we have not convinced enough people that voluntary health insurance is to be preferred to compulsory health insurance. Too many people, already convinced of the need for health insurance of some kind, express a preference for compulsory health insurance, or at least appear willing to accept it.

The principal reason for this failure, in my opinion, is the strict

"A safe and effective drug to use in controlling weight gain during pregnancy."

Coopersmith, B.L.: Dexedrine and Weight Control in Pregnancy, Am. J. Obst. & Gynec. (Oct.) 1949

Coopersmith reports the successful use of 'Dexedrine' Sulfate Tablets for weight control in a series of 100 obstetric patients. Because 'Dexedrine' curbed appetite and thus enabled these patients to follow their prescribed diets, control or reduction of weight was achieved in virtually all cases. 

It is noteworthy that other methods, including the use of thyroid, had previously failed to prevent excessive weight gain in these same individuals. "Thyroid", Coopersmith states, "increases the appetite . . . and is toxic in many cases."  "Dexedrine Sulfate", the report concludes, "is a safe and effective drug to use in controlling weight gain during pregnancy."

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for control of appetite  in weight reduction

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

enrollment policy that has been followed by almost all commercial carriers and by too many Blue Cross and Blue Shield plans. Group enrollment has been the rule, nongroup enrollment the exception. The time is past when individuals can be ignored in voluntary health insurance.

The next failure I would list is almost entirely limited to the nonprofit plans. This is the failure to offer more than one type of contract.

Of course, the group with very low incomes can afford only the lowest possible cost of protection—as, for example, ward accommodations on a full-service basis. This is by far the most important group to be protected, and an offering to them must never be priced out of the market.

But they are not the only group that needs and wants protection. Many people, higher in the income scale, want and can afford somewhat more elaborate accommodations. We must meet that demand.

There may be people who are unable to understand the simplest actuarial principles. There are some who would welcome the largesse of the Government upon any principles, or without principle. But I believe firmly that the great majority of our people can be made to understand the iniquities of such proposals; and that once they understand them, they will reject them in favor of the voluntary approach. —PAUL R. HAWLEY, M.D.

"Here's my first appendectomy, dear"

Medical Schools [*Cont. from* 58]

nals for a team of technicians, nurses, internes, and residents—a team with a veritable battery of new drugs and techniques at its command.

The statistician cited points out also that the total size of the freshman class in all medical schools averaged 6,016 for the ten years preceding the war. But with new schools and with increased enrollment in our older schools, the figure will soon exceed 7,000. He adds that during the years 1940-1948 the general population increased 12 per cent and the physician population 14 per cent—a relative increase of more than 16 per cent. He believes that, rather than the shortage predicted by Government planners, we will soon have an excess of physicians.

Among the bounties of S.1453 are Federal funds for scholarships. Innocent though these may seem, they open the door to political pressure on admissions committees to accept unqualified students. A further hazard is pressure on the schools to continue the education of failing students with political scholarships. The effect of loosing on the public a horde of poorly trained, politically favored practitioners is not at all difficult to estimate.

To combat S.1453 will require an all-out effort in every state. This measure is going to be a lot more difficult to defeat than the omnibus bill, S.1679.

Consider, now, another dangerous bill cast in the same mold. I refer to S.1411 (the National School Health Services Act of 1949). This measure promises prevention and treatment of the "physical and mental defects and conditions" of "all children between the ages of 5 and 17, inclusive, at-

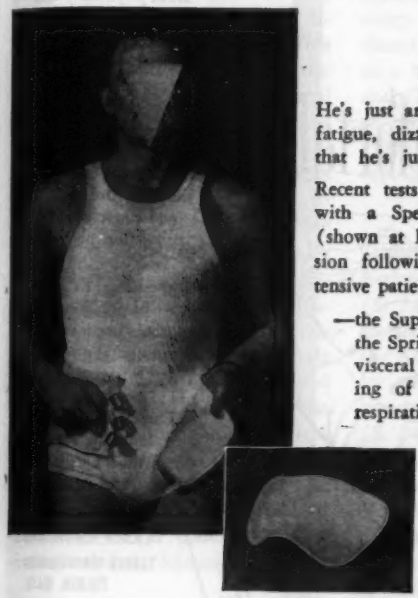
What They're Wearing

● At the doctor's request, I was preparing an expectant mother for a pelvimetry. I ushered her into our combination storage and dressing room, leaving her with instructions to undress and to don one of the robes hung there. When, after a reasonable length of time, the patient hadn't emerged, I rapped on the door and asked how she was making out. "I'm not sure," she answered, "if I have this thing on right."

I opened the door to give her a hand. There stood our full-blown Ob. patient, wearing the doctor's lead-rubber X-ray apron —and nothing else.

—KATHERINE WHITE, R.T.

LO-
the poor HYPOtensive



He's just another "chronic"—with cold feet, fatigue, dizziness, and a growing suspicion that he's just "half-alive"!

Recent tests* show that a Spencer Support with a Spencer Abdominal Spring Pad** (shown at left) effectively controls hypotension following sympathectomy. Other hypotensive patients likewise benefit because:

—the Support which improves posture and the Spring Pad which serves as a resilient visceral elevator combine to prevent pooling of blood, improve circulation and respiration, encourage muscle exercise.

—patient cooperation is assured because of *comfort* and an added sense of well-being.

—each Spencer is *individually designed, cut, and made* to meet medical requirements.

For a dealer in Spencer Supports, look in telephone book (see "Spencer corsetiere," "Spencer Support Shop," or Classified Section). Or write direct to us.

*Evans, James A., Bartels, Carl C., *Results of High Dorsolumbar Sympathectomy for Hypertension*, Annals of Internal Medicine 30: 307-329 (Feb.) 1949.

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*West. J. Surg., Obstet. & Gynec., 51:50, 1943; J.A.M.A., 128:490, 1945.

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tending school." It would thus socialize the medical care of a large segment of the population.

S.1411 would also allow the Federal Security Administrator to withhold funds allotted to the states and to pay such funds directly to private schools. This would violate the rights of the states and would permit Federal domination of the policies of the private schools. At its Atlantic City session in June, the AMA House of Delegates voted unanimously to oppose S.1411. It attacked the measure as "socialized medicine by the back door."

Both these bills—S.1453 and S.-1411—have been passed by the Senate. Both are now in the hands of the House rules committee and may be brought to the floor of the House immediately after Congress convenes on Jan. 3, 1950. If enacted into law, they will constitute another irrevocable step toward crushing Federal control and increased deficit financing—leading inevitably to moral and economic chaos.

Mr. Flynn's documented treatise, "The Road Ahead," leaves no room for doubt as to the inevitable destination of our present course. If every thinking person could be induced to read this book, to use it as a text, and to tell his Senators and Congressmen what he expects of them, it might turn the tide.

Meanwhile, we are approaching rapidly the point of no return.

—JAMES E. BUCKLEY, M.D.

EDITORS' NOTE: *The bill providing Federal aid for medical schools (S. 1453) was passed by the Senate without formal opposition from the AMA. In this respect it is similar to the bill providing Federal grants for school health services (S. 1411).*

Last June, however, the AMA delegates voted strong disapproval of S.1411. And they may this month disapprove S.1453, although such action was by no means certain as of early November. The AMA trustees were understood then to be generally against the bill, but had yet to crystallize their stand on it.

Many medical leaders interviewed see a grave possibility of domination of medical education through Federal grants. For this reason, and because of other objectionable features of S.1453, they oppose it vigorously.

Both this measure and S.1411 now await action by the House of Representatives.

Are Bad Debts Deductible?

Treasury lists three types of unrepaid loans that may reduce your income tax

● Maybe it isn't better to have loaned and lost than never to have loaned at all. But at least, in the former case, there's a consolation prize. Bad debts are among the deductions the income tax collector allows you when totaling up how much you owe Uncle Sam.

That doesn't mean you can deduct *every* unpaid debt. First, you must show that the money was loaned on an unconditional promise of repayment. Secondly, the debt must have become worthless during 1949. If it had no value at the close of 1948, or if there's a chance it will be repaid in 1950, you can't deduct it now.

These considerations mean that the $50 you slipped to a down-and-out friend can't be deducted, nor can that "loan" to your brother-in-law. You never really expected to be repaid, so for tax purposes they are gifts.

The tax law recognizes three classes of bad debts: (1) corporation bonds that became worthless during the year; (2) business or professional bad debts; and (3) non-business bad debts.

Fully worthless bonds are deductible as capital losses. Whether you should claim the loss as short-term or long-term (over six months) depends on your date of purchase. The date of worthlessness is always taken as the last day of the year, no matter what date during the year the bonds became wallpaper.

Undelivered Purchases

Unrepaid loans connected with your practice may be deducted on your Federal income tax return for the year in which they go sour. For example, suppose you paid $500 to a medical equipment supplier for a machine that was never delivered. You could not recoup your outlay because the supplier went broke in 1949. You may deduct the loss on your tax return for 1949 as a business bad debt.

Bad debts unconnected with your practice are also deductible. A personal loan gone bad, like that

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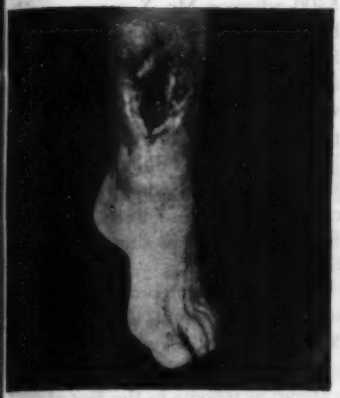
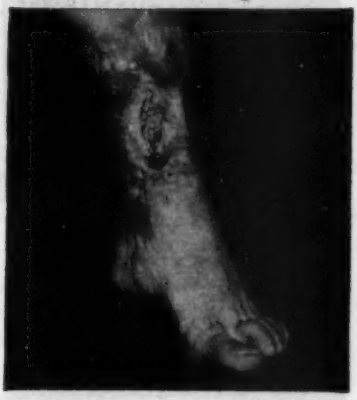
** Alfred J. Cronin, the author of this article, is a member of the staff of Murphy, Lanier & Quinn, accountants and tax consultants.*



Chronic osteomyelitis of *12 years' duration.* 14 surgical procedures failed to close the cavity. Pain and foul-smelling discharge caused patient to request amputation.



Treatment with Chloresium brought progressive closure of the cavity. Purulent drainage and odor stopped. Pinch grafts were successful and cavity closed completely.

CHLOROPHYLL HEALED

where other methods of treatment failed

The case shown above is one of a large series which resisted other methods of treatment—until Chloresium therapeutic chlorophyll preparations were used. The published record* shows that the majority of them not only *responded rapidly* to Chloresium's chlorophyll therapy, but *healed completely* in a relatively short time.

Results with Chloresium in acute cases have been equally effective. Faster healing, less infection, less scar tissue formation and quick deodorization of foul-smelling conditions have been obtained.

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*Boehme, E. J.	The Treatment of Chronic Leg Ulcers	The Lahey Clinic Bulletin, 4:242 (1946)
Carpenter, E. B.	Chlorophyll Therapy in 127 Cases of Chronic Osteomyelitis and Ulcers	Amer. J. Surgery, 77:162 (1949)
Cady, Jos. B. Morgan, W. S.	Treatment of Chronic Ulcers with Chlorophyll	Amer. J. Surgery, LXXV:4 (1948)
Johnson, Harold M.	Dermatologic evaluation...	Arch. Dermat. & Syph. 57:348 (1948)
Langley, W. D. Morgan, W. S.	Chlorophyll in the Treatment of Dermatoses	Penn. Med. Journal, Vol. 51; No. 1 (1948)

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*City*_____ *Zone*_____ *State*_____

$300 advance Mr. X never repaid before leaving for parts unknown, is an example. If you've compromised a loan—for example, if you were forced to accept $100 as repayment in full for the $500 you loaned Mr. Z—the difference can be subtracted from your taxable income. Claim these losses on your Federal tax form as short-term capital losses.

Unpaid bills for professional services seldom count as bad debts. Most medical books are kept on a cash basis, and such bills aren't entered as income in the first place. No deduction is allowed because no tax has been paid on them in previous years.

In listing bad debts—whether they are worthless bonds or forgotten loans—be ready to prove that the money can't be recovered. The evidence must show that you've made a real attempt to collect (including legal action, if the outstanding debt is substantial).

—ALFRED J. CRONIN

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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"The increases in hemoglobin were...

dramatic...rapid..."[1]

Independent controlled investigations continue to confirm the greater effectiveness and better tolerance of molybdenized ferrous sulfate (Mol-Iron) in the treatment of iron-deficiency anemia.

Typical findings:

"We have never had other iron salts so efficacious..."[1]

"More rapid... response than ferrous sulfate"[2]

"A true example of potentiation of the therapeutic action of iron."[3]

"Generally well tolerated... even in iron-intolerant patients..."[4]

White's Mol-iron *Tablets, Liquid*

MOLYBDENIZED FERROUS SULFATE

—a specially processed, co-precipitated, stable complex of molybdenum oxide 3 mg. (1/20 gr.) and ferrous sulfate 195 mg. (3 gr.). Recommended adult dosage: 2 tablets, t. i. d. Available in bottles of 100 and 1000 tablets and in a highly palatable Liquid, in bottles of 12 fluid ounces.

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2. Chesley, R. F., and Annitto, J. E.: Bull. Margaret Hague Maternity Hospital, 1:68-75 (Sept.) 1948.
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White LABORATORIES, Inc.,
Pharmaceutical Manufacturers, Newark 7, N. J.

more drive in life . . . sparked by citrus fruits and juices!

Among foods that fuel the human engine, citrus fruits and juices have a high energy output, their natural fruit sugars providing quick energy without digestive burden.[1,2] Equally abundant is their vitamin C content (a prerequisite of tissue health and vigor),[3] and other nutritional factors* so necessary for buoyant good health. In their remarkable nutritional enhancement of stamina,[5] growth,[4] and resistance to disease,[6] and their ready patient acceptance, citrus fruits must be ranked among essential foods . . . whether fresh, canned, concentrated or frozen . . . in pre- or postoperative supportive therapy, during pregnancy and lactation, or for infants and children.

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Oranges · Grapefruit · Tangerines

Have You an Equipment Inventory?

Here's how to set up a record that will help you in tax and insurance matters

• Maybe office fires, burst water pipes, or similar acts of God haven't tagged you for a property loss—yet. But take a tip from your colleagues who have been so plagued: What often hurts most of all is lack of adequate records to prove exactly how much insurance recovery or tax deduction you've got coming.

The best safeguard against the unrecoverable and the undeductible is, of course, an equipment inventory. Not only is it invaluable in case of casualty losses; it's also a big help in computing your income tax, since it lumps in one place nearly all the required information about your professional equipment and the depreciation on it.

Your secretary can easily set up such an inventory. While record sheets for this purpose are not, as a rule, available commercially, double-entry ledger sheets with the appropriate headings typed in will do nicely. The sheets can be kept in a standard, loose-leaf folder.

A good rule is to use one sheet for each major piece of equipment. The data recorded may well include date of purchase, probable life, purchase price, yearly depreciation, and current value.

The items that are listed in the inventory usually include all professional equipment costing more than $50. Likely candidates would be X-ray, diathermy, BMR, and EKG machines; autoclaves; examining tables; surgical lights; weight scales; desks; typewriters; fixtures; most reception-room and consultation-room furniture; etc.

You may also want your secretary to keep a record of the smaller items, some of which have considerable aggregate value. Surgical instruments and medical books come in this category. They can be listed by groups in your equipment inventory, instead of singly. If their useful life is estimated at less than a year, you can forget about the depreciation column.

Keeping up an equipment inventory is a snap. Entries are usually made only when you purchase new equipment or when computing depreciation for income-tax purposes. So, without giving your Girl Friday writer's cramp, you can acquire a record that may save you many dollars when misfortune strikes.

—J. D. OBERRENDER

The liquid oral penicillin that tastes good!

ESKACILLIN tastes so good that even young children actually like to take it.

But palatability is not ESKACILLIN'S only advantage. Unlike most extemporaneous "fruit syrup" mixtures, ESKACILLIN maintains its potency for 7 full days under refrigeration.

Each teaspoonful of ESKACILLIN contains 50,000 units of crystalline penicillin G—and produces a blood level equivalent to that obtained with a 50,000 unit penicillin tablet. ESKACILLIN is supplied in 2 fl. oz. bottles —containing 600,000 units of penicillin.

Eskacillin *the unusually palatable liquid penicillin for oral use*

Smith, Kline & French Laboratories, Philadelphia

paid medical care plan not endorsed by the defendants itemized statements that will enable the patient to be reimbursed under the plan to which he has subscribed.

"g. Refused to consult or assist, and encouraged others not to consult or assist, doctors who treat members of a prepaid medical care plan not endorsed by them.

"h. Spread false propaganda among doctors, hospitals, and the general public for the purpose of discrediting any prepaid medical care plan not endorsed by them.

"i. Agreed among themselves and with others not to compete with each other for prepaid medical care business or with other similar organizations approved by or affiliated with them.

"j. Succeeded in making hospital facilities in Oregon available only to members of defendant Oregon Medical Society and its component county medical societies, and restricted and excluded other qualified doctors cooperating in prepaid medical plans other than those sponsored or approved by the defendants from access to such facilities."

The summons concluded with a legal prayer that the "conspiracy in restraint of trade" be declared in violation of the Sherman Act; that the defendants be perpetually enjoined from carrying out further restraints; and that they be required to publish a statement in their journal (Northwest Medicine) "that it no longer be the policy of said medical societies to do those things which, as hereinbefore alleged, they have combined and conspired to do." The defendants, if found guilty, would also be required to pay the Government's legal costs.

The Trial

The trial did not get under way until Oct. 18, 1949. But pre-trial hearings had been held for months before that, during which depositions were taken from representatives of medical societies, prepay plans, lay health organizations, and the general public.

So much material had been accumulated in the course of the Oregon investigation that, if presented in detail, it would take weeks. What's more, there were still some 200 doctor-witnesses who might be heard, plus an undetermined number of lay witnesses.

In the opening arguments of the case, Philip Marcus, special assistant to Attorney General McGrath, charged that the "conspiracy" in Oregon was the "more heinous" for having been indulged in by a group of citizens in high esteem. In 1936, he said, "These defendants embarked upon a ruthless campaign to terrorize doctors who connected themselves with prepaid plans not approved [by the defendants]." Defense Attorney Nicholas Jaureguy denied flatly the charge of coercion by doctors in their re-

For the public good

The health and well-being of at least 1,000,000 Americans depends upon their discovery and treatment as diabetics. The American Diabetes Association is directing the year-round Diabetes Detection Drive to find the "1,000,000 unknown diabetics" and guide them to their own physicians for treatment.

THE AMES *Selftester* (TRADEMARK®) **AT ALL DRUGSTORES**

brings those with glycosuria to you for diagnosis.

A single home screening test for urine-sugar, the Ames Selftester* is a new approach to this detection problem. Like the clinical thermometer, it is sold directly to the public through druggstores. Also like the thermometer, it does not give a diagnosis, but only a warning.

the directions state:

1. The Selftester does not diagnose diabetes or any other disease. Its sole function is the detection of sugar (glucose) or sugar-like substances.
2. If reaction is positive, see your doctor at once. Sugar in your urine does not necessarily mean you have diabetes (nor does a negative result definitely exclude the presence of disease). But only your doctor, by medical examination and by additional laboratory tests, can tell why you show sugar.

THE AMES *Selftester* to detect
CLINITEST® to control
Brand • Reagent Tablets
} THE DIABETIC

*Approved by the Council of the American Diabetes Association and accepted for advertising in publications of the American Medical Association.

AMES COMPANY, INC • ELKHART, INDIANA

lations with prepayment groups.

Federal Judge Claude McColloch, to whose court the Oregon suit was assigned, has a high reputation for judicial integrity. He has stated that he does not want the Justice Department attorneys trying their case in the newspapers. Five of the department's legal staff have been working full-time on the Oregon suit.

A medical leader in Oregon says: "I know for a fact that the Government has no case here. I know that there has been no anti-trust act violation."

But guilty or not, the Oregon defendants have a hard and costly fight on their hands. When the Justice Department asked for their files and records, they made them available freely and without any process of law. To meet requests for data going back as far as twenty years has taken incalculable time and effort.

Dewey-Drive Aftermath

A Washington (D.C.) news analyst says: "It's curious that the case in Oregon was revived right after the medical profession there had had so much to do with the nomination of Thomas E. Dewey for President. A number of Oregon doctors had worked night and day to help get Dewey's name on the ballot. It was almost immediately thereafter that the Department of Justice slapped its anti-trust suit on them.

"It's interesting, too, that the Committee for the Nation's Health should have brought out its pamphlet, 'Restrictions on Free Enterprise in Medicine,' just when the Government needed some outside propaganda in support of its medical anti-trust activities.

"These things tie together too neatly to be coincidental."

Washington Pipelines

The Committee for the Nation's Health is seen as having many Washington pipelines through which to direct appeals for bigger and better investigations of organized medicine. For example: Mrs. Franklin D. Roosevelt, a vice-chairman of the committee, obviously needs no introduction to the White House. Miss Peggy Stein, a special representative of the CNH, used to work for the investigating committee headed by Mr. Truman when he was a Senator. Abe Fortas, a CNH director, is a legal colleague of Attorney General McGrath. William Reidy, formerly with Michael M. Davis, CNH executive head, is now health consultant to the Senate subcommittee on health; he works for Senator James E. Murray, whose compulsory sickness insurance bill the Committee for the Nation's Health has endorsed.

Assistant Attorney General Bergson was asked whether separate lawsuits would be initiated in most places where investigations are now being made. His answer was no: "For one thing, in a lot of those

places, we may find there is no evidence to justify the charges. Even if there is evidence, local suits may not be brought. A local group might be included, for instance, in an over-all national anti-trust suit."

Threat to Standards

If the Government wins its suits, interference with—and lowering of—medical standards is predicted. For people will then be able

to participate freely in prepayment plans of doubtful ethics, and medical societies will be prohibited from exercising the necessary control over their doctors.

Jerry Voorhis, executive secretary of the Cooperative Health Federation, says that while anti-trust indictments would make it easier for doctors to participate in group health plans, "We would rather have real agreement and conviction on the part of the medical societies that participation in co-ops is right. There is still a lot of misunderstanding. Much of it centers around the doctors' fear of lay control. We've got to prove to them this fear has no foundation."

'Doctors Frightened'

Voorhis adds: "Doctor after doctor has been frightened by advice that his practice with a group health cooperative would not be recognized as proper by his state or county medical society and that his professional standing would be endangered. Cases of this kind have no reference whatever to the professional ability or the ethical standards of the doctors who are involved.

"We are confronted also with such instances of discrimination as the refusal of a county medical society to admit to membership the doctors of a group health cooperative—even though the co-op hospital these doctors staff has been approved by the American Medical Association!"

Off to Jail?

Asked whether any individual doctors named by the Department of Justice in its suits might end up behind bars, Assistant Attorney General Bergson laughed. "No one yet has ever gone to jail for an anti-trust violation," he said.

If, as claimed by most doctors, the anti-trust investigations are politically inspired, the main object in conducting them may well be to discredit medicine before the

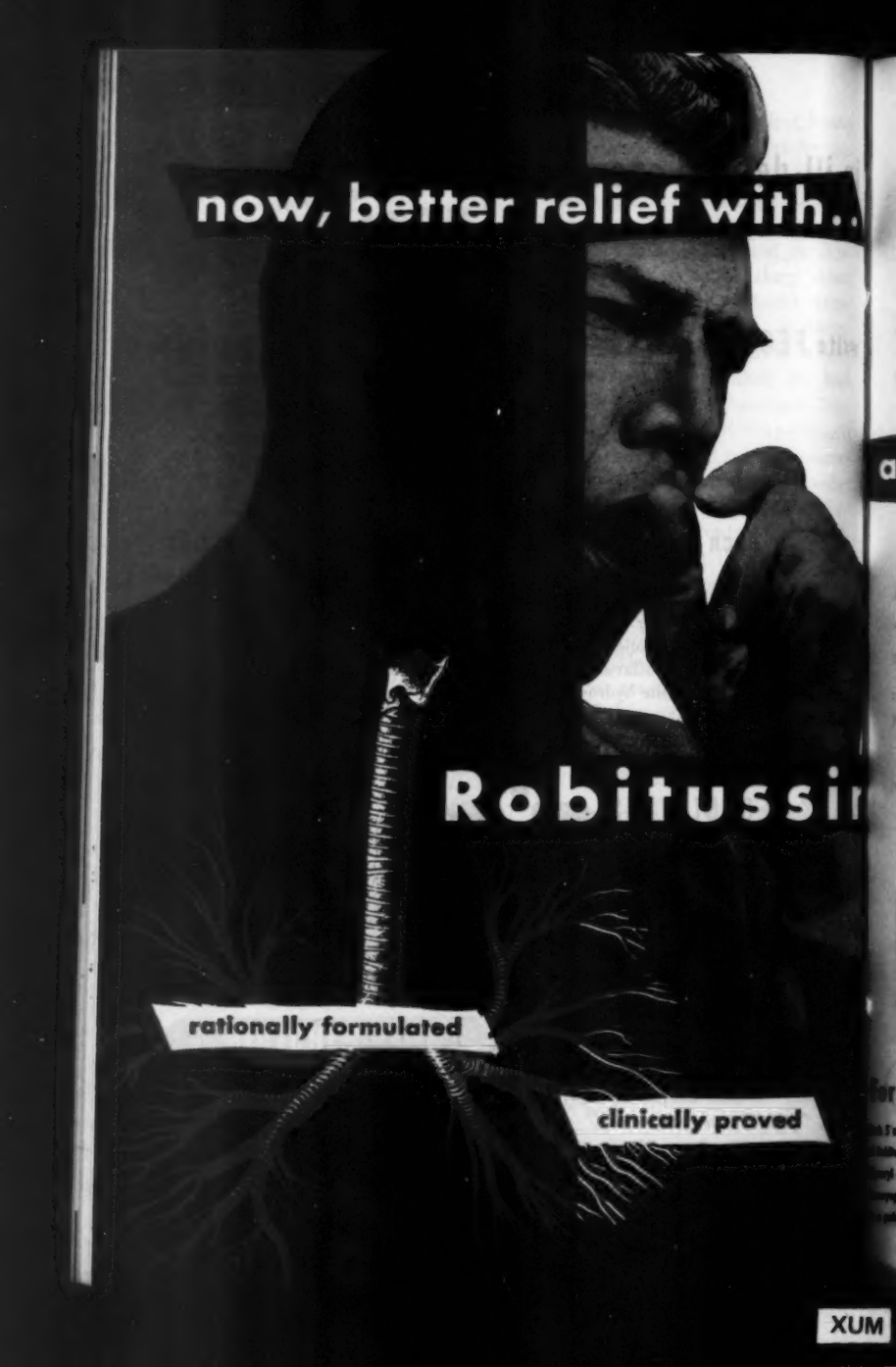
public, rather than to collect heavy fines or create any martyrs by imprisonment.

Some physicians charge that the Bureau of Internal Revenue has been told to turn the heat on doctors in retaliation for their stand against the Administration's compulsory health program. A doctor in one state mentioned to a colleague that shortly after he had sent a telegram to President Truman protesting the Murray-Dingell bill, he was jumped on by income-tax investigators. His colleague pooh-poohed any connection between the two events. The result was a wager that if the doubter sent a similar telegram to the White House, he, too, would be the subject of a tax probe within two months. This telegram was sent—and the sender lost his bet. An Internal Revenue agent called on him within a fortnight.

Tax Reprisals

"The quickest way to start a check-up of your income tax is to wire the President and tell him you don't like his program," the doctor now concludes.

While this man and a surprising number of medical society officers opposed to Government medicine have been tax-investigated, there's no *proof* of persecution. Congress has been asked, however, to look behind the scenes and to get the facts. The Arkansas Public Expenditures Council, for example, recently requested Senators John L. McClellan and J. W. Fulbright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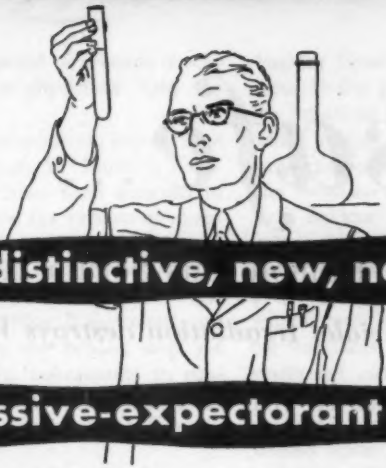

a distinctive, new, non-narcotic antitussive-expectorant

At last, something really new in cough syrups . . . something completely rational . . . clinically sound . . . Robitussin 'Robins'.

Robitussin employs glyceryl guaiacolate and desoxyephedrine hydrochloride, in a palatable aromatic syrup vehicle.

Glyceryl guaiacolate has proven an effective aid to expectoration, and a cough ameliorator with prolonged action, through its increase in and thinning of respiratory tract fluid;[1,2,3] yet it has no ill effect upon digestion.[1]

Desoxyephedrine's sympathomimetic action is also well recognized;[4,5,6] by relaxing spasm of the bronchial musculature and helping maintain normal respiratory smooth muscle tone, it greatly minimizes the provocation of cough from spasm.[5] At the same time it affords relief from psychic depression or a feeling of fatigue.

The syrupy vehicle, with its aromatic volatile oils, has a local demulcent effect. Furthermore, it assures patient cooperation by providing a base which makes Robitussin one of the most palatable of all antitussive-expectorants.

You will find Robitussin 'Robins' an exceptionally efficient, safe, therapeutic tool in the management of cough — for both adults and children.

DOSAGE: Children: one-half to one teaspoonful, according to age, three or more times daily. Adults: one or two teaspoonfuls, as necessary every two to three hours.

SUPPLIED: Pint and gallon bottles.

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A. H. ROBINS COMPANY, INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Robitussin

for rational
cough management

safe...

cannot cause Homologous Serum Hepatitis

BECAUSE: ***Ultraviolet Irradiation destroys Virus SH***

("...and stable for at least 8 years")*

*

"Experimental work carried out on dried plasma shows that under ordinary conditions of preservation, away from the light, it will keep, practically unchanged, all its essential qualities for at least eight years."

(Queries & Minor Notes, J.A.M.A. 141:300, Sept. 24, 1949)

Lyovac® Plasma

IRRADIATED

Supplied desiccated in vacuum bottles to yield 50 cc., 250 cc., and 500 cc. of virus-free, normal human plasma (980 mg. gamma globulin per 100 cc.), or smaller quantities of concentrated, hyperbolic plasma. Sharp & Dohme, Phila. 1, Pa.

SHARP & DOHME

LYOVAC *Normal Human* PLASMA IRRADIATED

to make a probe of revenue checks on Arkansas physicians. Said the council:

"There are recurring reports here that thousands of Internal Revenue agents have been assigned to check income tax returns of members of the medical profession in retaliation for their efforts against the Adminstration's stand on socialized medicine. If the reports are true, this is the boldest step yet taken by the bureaucrats to subjugate the individual American citizen to the whims of the Government.

"We believe that the sheer existence of widespread reports that a Federal agency is attempting to intimidate the medical profession calls for a Congressional investigation to determine the facts and to ascertain whether the affairs of the Bureau of Internal Revenue are being administered in a fair and impartial manner."

Newspaper Comment

The American Medical Association declares that "The intimidating tactics of the Anti-Trust Division of the Department of Justice against the medical profession have provoked a storm of editorial protest from influential newspapers throughout the nation. Many editorials have condemned the sudden eruption of politically motivated anti-trust investigations of medical societies daring to oppose compulsory health insurance."

The AMA then quotes the Los Angeles Times as follows: "It may occur to the general public that if the American Federation of Labor, which openly proposes to raise a large campaign fund to defeat certain members of Congress—particularly Senator Taft—is not investigated, then the AMA, which has sought to raise a much smaller campaign fund to protect itself from what it consider an assault on medical standards, ought not to be investigated either.

"The Department of Justice has made no move to investigate the United Mine Workers, whose virtual monopoly of coal mining is obviously far more hurtful to the public than anything the AMA does or attempts."

Says the Chicago Daily Tribune: "John L. Lewis and Philip Murray have called strikes which have made more than a million men idle . . . Yet Lewis and Murray cannot be charged with monopolistic practices because unions are exempt from prosecution under the anti-trust laws.

"If the members of the AMA were organized in a labor union and affiliated with the AFL or CIO, they could run out of business all prepaid medical care plans which did not pay tribute to the AMA. And no FBI agents could come snooping around, looking for evidence of monopoly."

From the Columbus Evening Dispatch: "The action of the Anti-Trust Division . . . is a shocking misuse of Federal authority . . .

Antihistaminic Therapy of the Common Cold

Nature of the Common Cold

Since the work of Kruse in Germany, and of Shibley and associates in this country, it has been generally accepted that the common cold is caused by a virus, as yet unidentified. Although no specific therapy has yet been discovered for the infective agent, investigators have noted a marked similarity between allergic symptoms and many of the symptoms of the cold. The report of Troescher-Elam and others that the nasal secretions of patients with colds contained twice as much histamine as was found in allergic rhinitis emphasized the allergic component of the common cold.

In an editorial in the J.A.M.A., September 10, 1949 on allergy in epidemiology of the common cold the view is expressed that cold-susceptible patients often present borderline or subclinical types of allergy. According to Fox and Livingston the common cold is actually an allergic response to the cold virus or its products.

The present-day concept of the phenomenon whereby latent pathogens located in the upper respiratory tract suddenly become the virulent secondary invaders of the common cold may be outlined as follows:

1 The cold virus comes in contact with the tissues of the upper respiratory tract.

2 An allergic reaction follows characterized by edema of the mucous membranes.

3 There may be an associated trigger mechanism such as chilling, ingestion of food to which one is sensitive, etc., which further stimulates the allergic reaction.

4 The edematous mucous membranes lose their normal protective powers and provide a better culture medium for the cold virus and other pathogens.

5 Further invasion of the body by pathogens may follow, causing the complications of the common cold.

Thus, it is readily seen that counteracting the allergic reaction can break the chain in this course of events.

The Role of Antihistaminics

In the September, 1947 issue of the United States Naval Medical Bulletin, Brewster reported that antihistaminic therapy in the common cold gave unusually satisfactory results. In a later series of 572 patients treated with any one of five different antihistaminics

results were obtained which confirmed this earlier impression. Similar findings were reported by Gordon on 500 cases of upper respiratory infection, and by Murray on 494 patients treated with antihistaminics.

These studies point out several important facts:

a that 70-90% of colds are aborted or alleviated with antihistaminic therapy;

b that the effectiveness of treatment depends on prompt institution of therapy;

c that antihistaminics are effective as a group;

d that the reduction of sneezing and coughing usually effected, regardless of the duration of the cold itself, reduces the spread of the common cold by eliminating droplet exposure.

Therapy

Inhiston is the potent antihistaminic 1-phenyl-1-(2-pyridyl)-3-dimethylaminopropane characterized by effectiveness of antihistaminic action and low incidence of undesirable side-effects. It has been proven in numerous clinical studies in a variety of clinical conditions. Medical literature has appeared based on comparative clinical studies stating that this particular compound is superior to some of the earlier preparations in effectiveness and absence of side-effects. Laboratory studies show that the therapeutic index—the ratio of potency to toxicity—of *Inhiston* is 135.* This compares most favorably with the ratios of potency to toxicity of widely used older antihistaminics which range from 48 to 70. Therefore, the maximum recommended daily dosage of *Inhiston* is only 60 mg. whereas the recommended dosage of most other antihistaminics must be 100 mg. or more, per day. *Inhiston's* lower effective dosage level is of real advantage since it further reduces the possibility of side-effects.

Inhiston, therefore, is a truly effective antihistaminic for control of the common cold. When taken at the first sign of a cold it can abort the cold. Taken later, *Inhiston* helps shorten the duration of the cold, reducing cross-infection by stopping excessive nasal secretion. Its availability without prescription indicates clinical safety and enables each individual to have it within reach at the very first sign of the common cold, the optimum time to commence antihistaminic therapy.

The *Inhiston* package is plainly and carefully labeled to emphasize when the drug should be taken and when discontinued, and how much should be taken. A separate dosage schedule is given for children, and specific warning is made in regard to possible drowsiness. Professional samples of *Inhiston* are available upon request.

Union Pharmaceutical Co., Montclair, N.J. *THERAPEUTIC INDEX = $\frac{LD_{50}}{ED_{50}}$

The reason behind this obviously political persecution of one of the nation's most respected professional groups is childishly transparent. The AMA has vigorously opposed President Truman's state medicine proposal. Therefore, the doctors are to be put on the spot and smeared in the eyes of the public."

Concludes the Wall Street Journal: "The Administration's health scheme would be a Government monopoly to which every citizen would be compelled to contribute. In other words, the same Administration whose trust-busters charge the medical societies with monopoly wants to create an absolute and unbustable medical monopoly [of its own]."

To conduct anti-trust investigations of a profession as large as medicine and then to press charges in courts all over the country is a long-term job. But the Administration forces are working on a long-term basis. They're looking forward to 1952; and 1952 is still three years off.

Votes in '52

If private medicine is brought into disrepute by 1950, the Murray-Dingell bill will stand a good chance in 1951. And if compulsory health insurance can be enacted by 1951, it will mean votes for Truman in 1952.

It's as though Chancellor Bismarck or David Lloyd George were calling the signals.

—WILLIAM ALAN RICHARDSON

PROVED

UNDER ACTUAL PRACTICING CONDITIONS

BENZEDREX INHALER

SO MUCH BETTER THAT WE HAVE DISCONTINUED BENZEDRINE* INHALER

Our new BENZEDREX INHALER was tested by rhinologists in controlled studies for more than two years. Reports were unanimously enthusiastic.

Nevertheless, to make absolutely certain that BENZEDREX INHALER was the best volatile vasoconstrictor ever developed we decided to test it with a large segment of the medical profession under actual practicing conditions.

We therefore replaced 'Benzedrine' Inhaler with BENZEDREX INHALER in the entire state of California. Now, after more than a year's use, California physicians tell us that they and their patients find BENZEDREX INHALER the best inhaler they have ever used.

BENZEDREX INHALER has exactly the same agreeable odor as 'Benzedrine' Inhaler, but gives even more effective and prolonged shrinkage, and does NOT produce excitation or wakefulness.

*Benzedrine' (racemic amphetamine, S.K.F.) and 'Benzedrex' T.M. Reg. U.S. Pat. Off.

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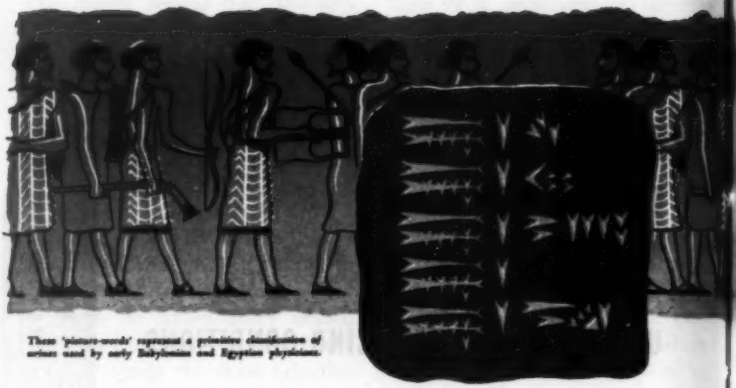


These 'picture-words' represent a primitive classification of urines used by early Babylonian and Egyptian physicians.

centuries to perfect seconds to perform

When Sumerian and Babylonian physicians, *circa* 4000 B.C., noted the varying colors and constitutions of the "water of the phallus," they were probably not the first uroscopists in history. They were assuredly not the last, for fifty-odd centuries were to elapse before Fehling's first paper on the copper reduction test for urine-sugar appeared in 1848.

But centuries to perfect diagnostic procedures are condensed into seconds to perform the reliable *Clinitest*® method for urine-sugar levels. From start to finish, the test takes less than a minute. This tablet method is simplicity itself . . . readily learned by every diabetic patient. External heating is uniquely eliminated by the *Clinitest* procedure. Routine test interpretation is made easy.

AMES

Clinitest

for urine-sugar analysis

AMES COMPANY, INC. • ELKHART, INDIANA

Doctor's Quiz [*Cont. from* 61]

by Schnicklefritz of Vienna:

1. *The Insurance Attitude.* To all and sundry, you say simply, "I know I'm going to fail." This is not pessimism, but a disguised statement that really means, "If I flunk, my judgment was correct; if I pass, what a nice surprise!" A variation is to bet a dollar that you'll flunk. If you do flunk, you're a buck to the good. If you pass, it's worth the money.

2. *The Advance Alibi.* It is two days before the examination. You have studied for four months. If you read another page, your cerebrum will burst into small fragments. Conscience dictates that the engorgement continue, but willpower fails. Your alibi takes shape: "Well, I can't know *everything*. I know the subject, but if they want to flunk me, they can flunk me. Let's go to the movies."

If you pass the examination, it was a pipe. If you fail, it's because you're the devil-may-care type who goes to a movie instead of staying home to study.

For the Sane Only

3. *The Sensible Attitude.* This starts off with, "I've been studying this stuff for three (four, five) years. If I don't know it by now, I'll never learn it by next Thursday." Then you cram like mad. Two minutes before the examination, you're a nervous wreck because you can't remember the histopathology of von Hippel-Lindau's disease.

For a change of pace, you may modify the Sensible Attitude by asking yourself, over and over again, "What have I got to be afraid of?" You circulate among the other candidates, instilling in them your own stalwart spirit. You don't collapse until you see the first question of the exam.

No matter what his advance attitude, every M.D.-examinee tries to guess which questions he'll be asked. The most successful at this game soon acquire reputations as dopesters. There are three principal dopester groups: (a) the intuitive, (b) the rationalists, and (c) the inside-information men.

For the Psychic Strictly

The intuitive feel that a certain question will be asked—"because." They are intellectually akin to women who just *know* something is going to happen. You study the question these men feel will be asked because it's easier to study it than to fight it. As it turns out, the question is not asked. In its stead is one you had a hunch about yourself, but didn't get around to studying.

The rationalist, on the other hand, knows a question will be asked because:

¶ It has been asked in the past.
¶ It has *not* been asked in the past.
¶ It is about time to ask it.
¶ It logically should be asked.

The rationalists bat about even

with the intuitionists, at approximately .006.

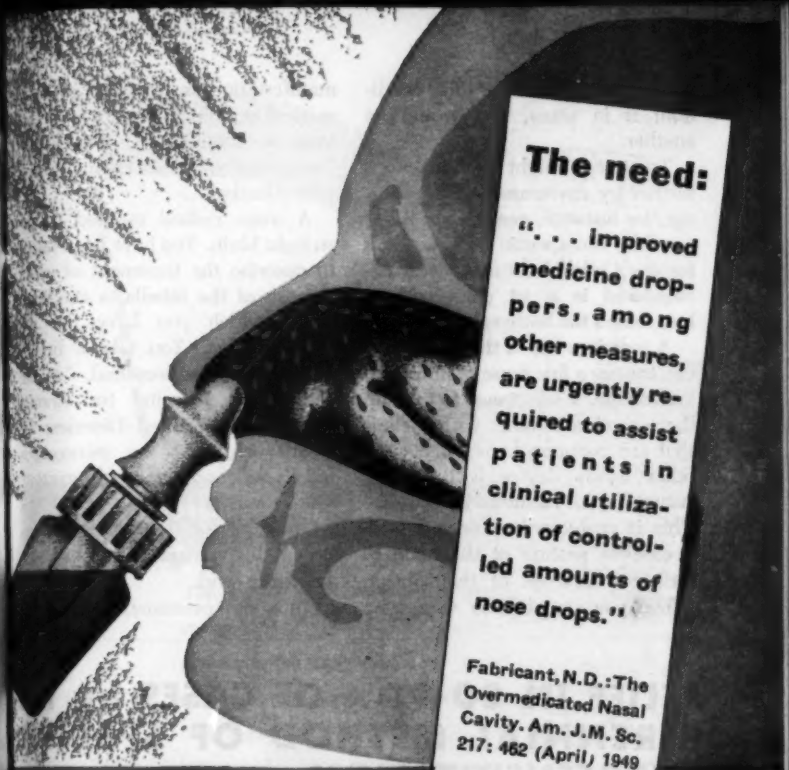
The third category of dopesters, the feed-box boys, are reluctant to divulge what will be asked, but less reluctant to tell how they know. A member of the examining board has a cousin; the cousin belongs to a lodge; the candidate's brother-in-law has an uncle who is corresponding secretary of the lodge. (P. S.—The candidate flunks.)

The Art of Obfuscation

Once the exam is under way, everyone operates under his own semi-secret formula. The general idea is to hit hard when you know the answer, plead lack of time to expound details when you don't. Illegible handwriting, with only a sprinkling of recognizable words, is permissible in moderation. But for the major emergency there are subtler procedures, tried and tested through the years.

The first is to misconstrue the question deliberately and to discuss something you know. Another is to go into an elaboration of a single phase of the answer. A third is to answer the question tangentially.

To illustrate: The examiner has asked, "How would you treat Colle's fracture?" The answer somehow evades you. So you dwell on various refinements of the etiology of Colle's fracture, such as falling off the roof with a load on. You explain that your treatment would be modified by conditions. If the patient were an elderly diabetic with terminal cancer in pulmonary



The need:

". . . improved medicine droppers, among other measures, are urgently required to assist patients in clinical utilization of controlled amounts of nose drops."

Fabricant, N.D.: The Overmedicated Nasal Cavity. Am. J.M. Sc. 217: 462 (April) 1949

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the answer:

JETOMIZER®
NASAL APPLICATOR

Superior to droppers or sprays

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JETOMIZER makes it possible to administer nasal medication efficiently and with optimum safety and convenience.

- Distributes medication throughout the nasal airways
- Minimizes danger of serious overdosage
- No risk of injuring delicate tissue
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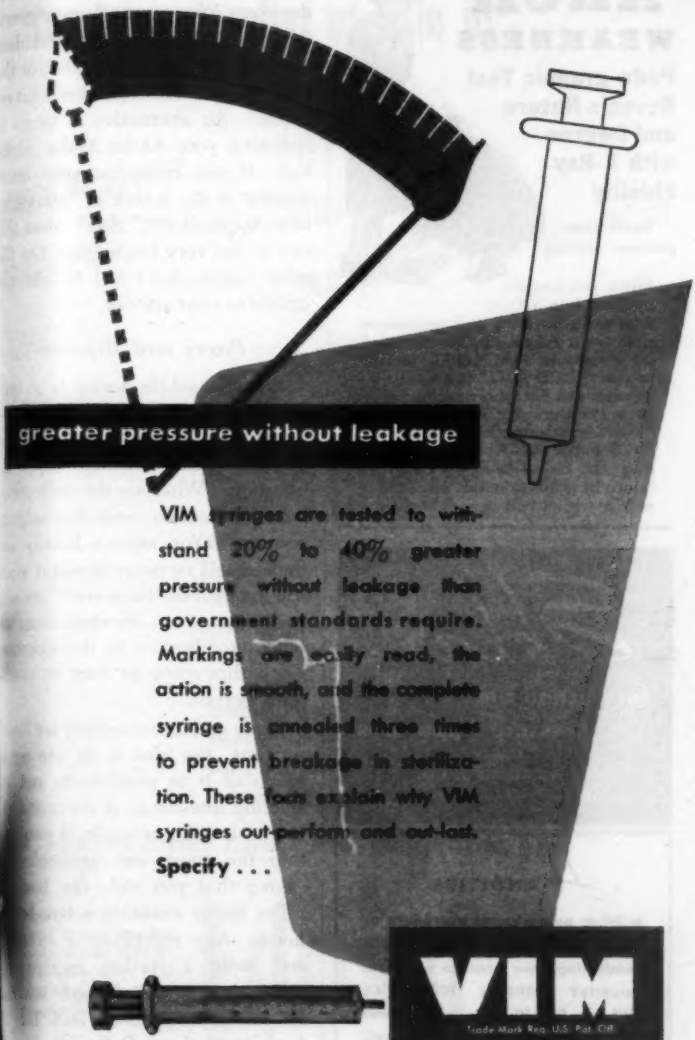
edema, that would be one condition; if in utero, that would be another.

Treatment might be influenced further by environment. In an air age, for instance, one must consider possible therapeutic modifications for the Colle's fracture patient encountered in a jet plane. Then, too, there's the bathysphere.

A judicious use of the "et cetera" can convey a fine sense of unlimited knowledge, a reluctance to take up the examiner's time with details that are common knowledge. Another handy device is the word "usual," as in "the usual procedure." This is customarily rendered with a careless gesture of the hand to indicate dismissal of the subject. When you are not sure whether a manifestation is frequent or rare, marked or mild, there are such apt tools as "sometimes," "somewhat," "occasionally," and (better) "not infrequently."

A more radical method is the straight bluff. You have been asked to describe the treatment of cysticercosis of the fabella, a condition about which you have not the slightest idea. You take a breath and step off the deep end. "At the Balderwich Hospital for Cranial Dystocia and Allied Diseases, we treat such cases by intravenous mare's milk and careful observation. Our results are 95 per cent." This strategy is, for the most part, unacceptably vulnerable, but has been known to work.

In an oral examination, the oper-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ing gambit can often be the most decisive. Your most effective greeting to the examiner is: "President Truman (or Uncle Sylvester, or the Health Commissioner) sends his regards." An alternative is to go in swinging your Alpha Alpha Alpha key. If you recognize your interrogator as the author of "Intrathoracic Appendicitis," don't blurt this out at the very beginning. On the other hand, don't fail to cite the article in your answer.

Parry and Riposte

A rather subtle device is to quiz the quizzer. Like dealing from the bottom of the deck, this calls for a specialized knack. Take the question: "What are the indications for a pancreatico-cerebellar-salpingectomy?" You answer hastily and then say, "I've never found it much use in cirrhosis—have you?" As soon as the examiner answers, snap another qualification to the question. Keep this going as long as conditions permit.

Since oral examinations are based on time, the idea is to use up as much of it as possible in not answering questions. A diversion can be created, for example, if you limp into the room and apologize by saying that you rode the last 117 miles to the exam on a two-legged horse. Any red-blooded examiner will want a further explanation. Similarly, you might ask whether he enjoys the hotel, and has he been to Madame Foffee's?

But never assume the examiner has no tricks of his own. For one

thing, he's probably a consummate master of the poker face and the unbatting eye. He begins coldly: "Atresia of the cardia." You proceed without benefit of traffic lights, signposts, or known destination. When you run down, he states another condition and away you go again.

Needle Work

As a refinement, he may interrupt once in a while, and with a gently rising inflection repeat a phrase you have just uttered. There is no indication whether he agrees, disagrees, or merely forgot to have his cerumen removed.

Or he may walk up and down while asking questions, impatiently cutting short your obviously knowing answers. Sooner or later, he comes to something about which you are shaky. From then on, he worries that particular subject until he has explored every by-path of your misinformation in the matter.

Examination results are known to the board the next day. As a matter of dignity, however, it customarily waits six months before announcing them. This time you can profitably spend in recalling to what extent you answered incompletely, and in giving perfect if belated answers to your reflection in the mirror.

The consolation is that some day you will not have to take any more examinations. That day often comes as early as three months before you retire. —THEODORE KAMHOLTZ, M.D.

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The Newsvane

Non-Payers of AMA Tax May Be Penalized

Members of the Washington State Medical Association, only state society to make the AMA $25 assessment compulsory, are wondering what will happen when the December 31 deadline rolls around. Some of them predict the penalties for non-payers will include: loss of membership in county, state, and national societies; withdrawal of hospital staff privileges; cancellation of medical liability coverage; and invalidation of any local health-and-accident insurance dependent upon medical society membership. What's more, local M.D.'s forecast, each errant physician's wife will be read out of her county and state auxiliary.

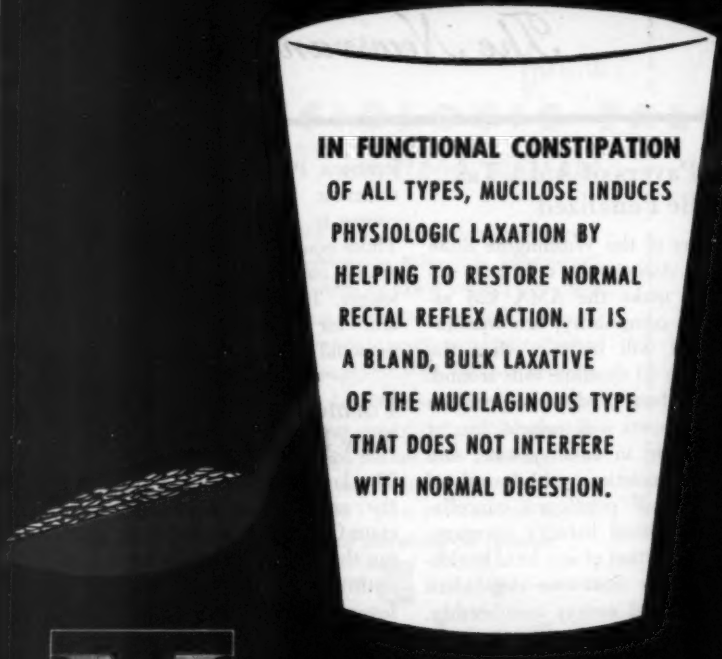
G.P.'s Offered Training In Anesthesiology

Purpose of the nationwide G.P. refresher course now offered by the American Society of Anesthesiologists is to help counter the shortage of anesthesiologists, especially in rural areas. The ASA has set up some seventy training centers where any practicing M.D. may hear lectures and attend demonstrations. Physicians close to an instruction center may take the course in one-day-a-week sessions. Those coming from a distance may attend continuously for a week or longer. Instructors are also available for telephone, telegraph, or personal consultation.

Former NPC Executives Now Head the NIPS

The laymen who for ten years ran the now-defunct National Physicians Committee are currently guiding the shakedown cruise of a new outfit: the National Institue of Professional Services. Chief NIPSites are Arthur L. Conrad, M. H. Petersen, and John M. Pratt, all former NPC executives. The new corporation has its headquarters in Chicago, is open for business in the fight against "the creeping encroachment of collectivist doctrines and deeds."

First NIPS project in the medical field was the sending of Economist Melchior Palyi to Europe for an on-the-spot study of Government medicine. Pending Palyi's return, his report was promoted (sight unseen) to each county medical society. Says Pratt: "There is not and never has been a docu-



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...nt even remotely comparable to ...."

Another NIPS project has been a fund-raising campaign among doctors in behalf of Spiritual Mobilization, a Los Angeles group aimed at "perpetuating freedom in America."

Although NIPS (unlike NPC) has no M.D. board of directors, many of its fund-raising letters have been sent out with prescription-blank endorsements by physicians who served formerly as NPC trustees.

Dentist Population Shown Gaining

Physicians still outnumber dentists better than two to one in the U.S., despite healthy gains chalked up recently by the latter. Between 1947 and 1949, the dentists' ranks increased by 5,647. The latest professional census shows the following totals: 86,904 living dentists; 202,516 living physicians.

AMA Cordiality Thaws Labor Opposition

Recent AMA press conferences are paying off, judging from the reaction of labor reporter Hollace Ransdell. "I was prepared for a cold reception," he writes in the CIO News, "but my enemy hand was grasped as warmly as if I were an ardent booster for the AMA. We labor people sometimes get to thinking the reactionaries have horns. The truth is, they look pretty much the same as the people on labor's side. The AMA leaders are no exception. They look okay.

"The present AMA campaign," he concludes, "is built on different lines than Fishbein followed. You catch more flies with sugar than with vinegar."

Physicians Best Known In the Home Towns

Of three major professional groups —physicians, dentists, and lawyers —physicians are the best-known in their home communities. A survey by the Iowa Bar Association shows that practically everyone in Iowa —98 per cent—can reel off the name of a local doctor. Dentists and lawyers were named by 94 per cent and 89 per cent, respectively.

The survey, which covered such topics as "What Iowans Like and Dislike About Lawyers," also took up the subject of fees. It found that lawyers are the group most frequently accused of overcharging. Their fees were considered too high by 56 per cent of the respondents. Doctors were accused of overcharging by 41 per cent, dentists by 40 per cent.

Local P.R. Bureaus Aid AMA Education Drive

Leaders of the AMA National Education Campaign have consistently urged establishment of county society public relations bureaus to

spearhead the drive locally. The problem has been how to get these local bureaus set up and running as a team. The New York State medical society has done it this way:

Dividing the state into four areas, the society assigned a field representative of its public relations bureau to each area. Each field man tours the counties assigned him, working with county officers to organize public relations committees where they are lacking, and suggesting improvements in existing agencies. The local bureaus assign speakers, distribute literature, and arrange cooperation with other groups sympathetic to medicine's campaign.

The Male Animal Is Thoroughly Mated

If it's true, as doctors often say, that married men are healthier than bachelors, the American male is in better shape today than ever before. The Metropolitan Life Insurance Company reports that more men are married and raising families than at any time in the past. Of the 35½ million husbands in the U.S., 34 million of them are living with their wives.

Air M.D.'s Set Up Specialty Board

To encourage more doctors to take up aviation medicine, the Aero Medical Association recently appointed its own interim specialty

The common occurrence of mixed infections in burns and chronic wounds suggests the use of an antibacterial agent with a wide antibacterial spectrum. Furacin, effective against the majority of wound bacteria in vivo, is receiving favorable and steadily increasing mention in the literature for such conditions.* Furacin® brand of nitrofurazone, is available as Furacin Soluble Dressing (N.N.R.) and as Furacin Solution (N.N.R.) containing 0.2 per cent Furacin. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

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*Bigler, J.: Chicago M. Soc. Bull. 50:269, 1947 • Coakley, W. A. et al.: Plast. & Reconstruct. Surg. 2:637 (Nov.) 1948 • Curtis, L.: Surg. Clin. N. A. 1466 (Dec.) 1947 • Downing, J. et al.: J. A. M. A. 133:299, 1947 • Johnson, H.: Arch. Dermat. & Syph. 57:348, 1948 • Mayo, J.: J. M. A. Georgia 36:263, 1947 • McCollough, N.: Indust. Med. 16:128, 1947 • Nib, J. et al.: Plast. & Reconstruct. Surg. 3:245, 1948 • Ryan, T.: U. S. Nav. M. Bull. 47:901, 1947 • Shipley, E. et al.: Surg., Gynec. & Obst. 84:366, 1947 • Snyder, M. et al.: Mil. Surgeon 97:330, 1945.

board. It will set up standards, certify specialists, and guide medical schools in the preparation of aero-medical training programs. The association hopes that ultimately its board will be added to the sixteen specialty boards now recognized by the AMA.

Spurs Search for Quicker Cancer Detection Test

Checking everyone once a year for cancer by present methods, says the American Cancer Society, would keep every doctor in the country busy on that task alone. At its recent conference on cancer detection, the society decided to:

¶ Push the search for a simple test for cancer; four blood tests of possible promise were discussed.

¶ Improve and expand the present 240 cancer-detection centers, now booked up weeks and months ahead.

¶ Cooperate in X-ray surveys to check possible indications of lung cancer.

Cites M.D. Responsibility In Philanthropic Drives

The public, contributing each year to t.b., heart, cancer, and similar campaigns, is going to expect the medical profession to report concrete gains in these fields. So opines the Illinois Medical Journal. "The profession individually and collectively has accepted a significant responsibility in these drives," it says. "We should inventory our

position more critically than we have to date."

The Journal adds, "A discovery of the cause or cure of cancer, for example, would be a substantial influence in retaining our present method of practice. Failure to show gains in conquering cancer, heart disease, or poliomyelitis from one year to another may react to our detriment."

Wants Disinterested Team To Study Health Care

What the nation's health problem calls for, editorializes the New York Daily News, is a Government-appointed commission, comprised of men like Bernard Baruch, Karl Compton, John Hancock, and Vannevar Bush, "to dig into the subject and give us a detailed report." Comments the News: "Until then, Congress would be foolish to pass any sweeping medical care laws."

Though viewing the AMA's itinerant press conference as a "traveling medicine show," the News credits association officials "for doing their level best to furnish frank answers." But, it adds, "these doctors were so much like politicians that we felt like yelling, 'Is there a doctor in the house?'

"We all know," continues the country's biggest-circulation newspaper, "that the rich and the poor in the United States get the best medical care in the world. But what about the millions of people in the middle? They don't make enough

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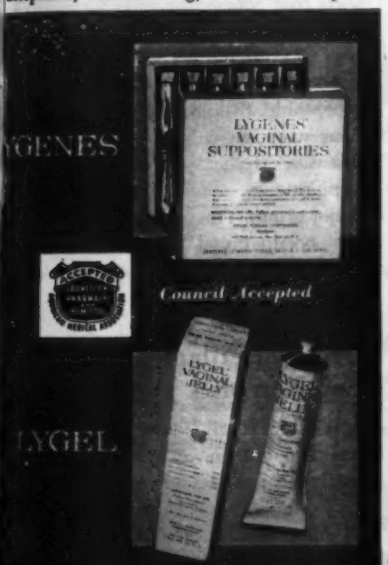

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for top-drawer service in serious illness, but make too much to qualify for the clinics. What plans, short of state medicine a la Truman and Ewing, has the medical profession for curing this situation?"

There are "several hundred questions on the subject," the News believes, that need clearing up: "The AMA hasn't answered them yet, and neither have the state medicine people."

Life Insurance Applicants Prove Physically Fit

The Institute of Life Insurance reports that Americans seem to be in excellent shape physically. Of last year's 7 million life insurance policy applicants, 96 per cent were found acceptable. About half the rejections were for cardiovascular-renal diseases. Medical histories of past impairments eliminated another major group. The rest were rejected for occupational hazards, overweight conditions, a variety of other physical findings.

Druggists Blame Doctors For Narcotics Violations

A Federal grand jury in Detroit has brought in a report on the "vicious practice" whereby doctors give narcotics orders to druggists by telephone, without having written prescriptions on file. Some of the druggists who testified during the inquiry said they had accepted such orders only because the doctors concerned had threatened

them with loss of patronage if they didn't comply. The grand jury concluded that such practices were prevalent not only in Michigan but throughout the country. It urged the Federal Government to prosecute the offenders.

Little Man Who Isn't There Haunts British

Already floundering in a welter of paperwork, British doctors are now plagued with another chore: weeding out duplicate names on their lists of patients. Root of the trouble is that many Britishers insist on registering with more than one doctor. This, of course, makes it practically impossible for the physician to tell whether the names on his list represent his patients or someone else's. In a number of communities, the doctors' lists total more than the area's population.

The Ministry of Health warns that if duplicates aren't eliminated soon, it may have to set up a central register to insure more accurate records.

Air Force Launches Plan For Dependents' Care

Supplying medical care for servicemen's dependents has become such a problem that the Air Force is trying a new system to ease the strain on medical personnel. Base commanders have been authorized to form voluntary medical care associations in which dependents are cared for by civilian M.D.'s. The

"I hate to bother you, doctor..."

Here's a way to eliminate telephone diagnosis. When a patient calls to complain of headache, neuritis or neuralgia pain, why not do this—Recommend Anacin tablets for temporary relief. Then see the patient at your first opportunity. Anacin is the dependable "A-P-C" formula that gives *fast* effective relief, over a *long* period of time. It's easily available to you and your patients at all hospital pharmacies and drug stores.

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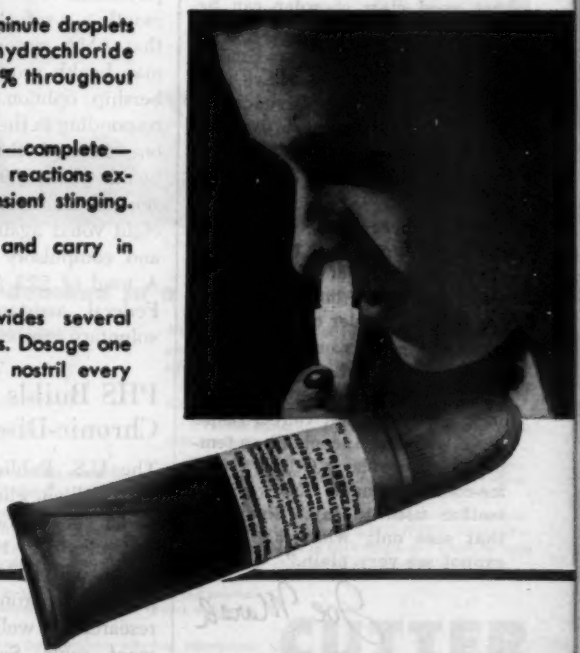

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dependents pay part of the cost.

These charges are estimated to be less than a civilian would pay for similar care. But the plan has, to date, met with a cool reception. Enlisted men and junior officers say they can't afford even minimum charges for dependents' care. General attitude is that the Government is obligated to provide it.

Capital M.D.'s Vote Down Truman Plan, 40-to-1

Results of a health-insurance referendum among District of Columbia physicians were being hailed last month as a refutation of the charge that AMA opposition to the Truman health program flaunts membership opinion. Of 918 doctors responding in the poll, only twenty-one favored the Administration's health plan; 869 called for extension of voluntary plans; twenty-eight voted against both voluntary and compulsory health insurance. A total of 222 physicians favored Federal assistance in extending voluntary insurance to the indigent.

PHS Builds Hospital for Chronic-Disease Study

The U.S. Public Health Service's $40 million clinical center, now under construction at the National Institutes of Health (Bethesda, Md.), will tackle the problem of long-term chronic disease from a research as well as from a treatment angle. Scheduled for completion in 1952, the center will

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study selected cases of mental illness, cancer, heart and circulatory ailments, diseases of metabolism, and some types of infectious and tropical sickness. Patients from all parts of the country will be eligible for acceptance upon referral by physicians, hospitals, or other medical institutions.

Explains Surgeon General Leonard A. Scheele: "Let's suppose that a new diet for high blood pressure seemed promising. The National Heart Institute would announce that it could accept, say, fifty patients, aged 40 to 60. Upon admission, they would receive a thorough work-up, then be placed on the new diet. Later, another group would be admitted, until a series of 300 or more cases had been studied.

"With patients and all members of the medical team in the same quarters," he points out, "the series could be completed and the treatment evaluated in far less time than is now required, when the combined results of different hospitals with different medical staffs must be awaited."

Lobbying Miracle Seen in Defeat of Plan No. 1

"Some of our previously better-known lobbies—farmers, business, labor, veterans—are in the way of being outclassed by a fairly new addition to pressure groups that operate on Congress. This is the doctors." So writes Washington-wise correspondent Thomas L.

Stokes of the Scripps-Howard newspaper chain. "Though a comparatively small group, they performed something close to a miracle by defeating in the Senate the proposal to create a new Department of Welfare."

Adds Stokes: "Never was there such a bombardment of Congress as that by the AMA. One Senator who favored the new department said he was called so often by doctors, the night before the Senate was to act, that he finally had to stop answering his telephone."

Last month the profession was taking the Stokes story as more complimentary than otherwise. Editorialized California Medicine, official organ of that state's medical society: "For many years the word 'lobby' has caused doctors to shy away from any endeavor to influence legislation . . . The American people have long since recognized [lobbying] as nothing more than exercise of the privilege of petitioning the Government, which is specifically set forth in the Bill of Rights."

Concludes the journal: "If this is lobbying, let us have more of it."

Hospitals Accused of Spreading T.B.

By failing to provide routine chest X-rays for incoming patients, some 4,000 general hospitals are needlessly exposing both patients and staff members to t.b. infection. So says science writer Albert Q. Maisel in a recent Woman's Home Com-

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helps you fight intranasal infection

Par-Pen provides: 1. The more rapid, more prolonged shrinkage of Council-accepted Aqueous Solution Paredrine Hydrobromide. The Paredrine promotes ventilation and drainage and thus facilitates bacteriostasis at the site of infection.

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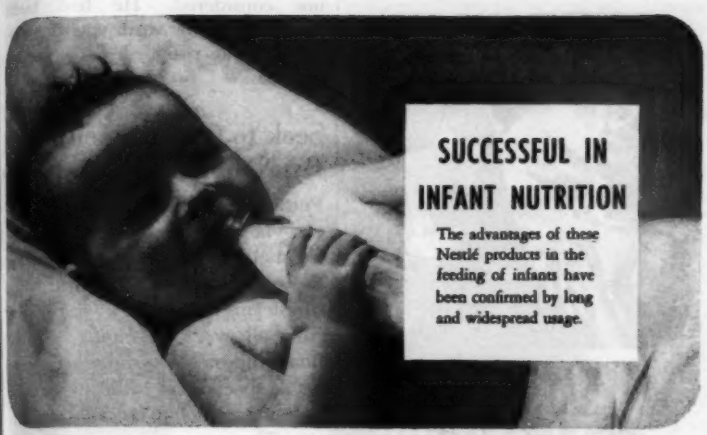
panion article, "Is Your Hospital Spreading Tuberculosis?"

Maisel estimates that between 90,000 and 250,000 patients with undiagnosed t.b. are admitted every year to general hospitals throughout the country. Only 247 hospitals give them a routine entrance X-ray; only twenty-seven more are planning to institute the practice, he says.

Whitaker & Baxter Reply To Disgruntled Staffer

Peace has been restored to AMA campaign headquarters following the recent teapot tempest arising from the resignation of David Brown, editorial director of the campaign. Brown, former Liberty magazine editor, announced to the press that he was quitting because he disagreed with Whitaker-Baxter methods. In particular, he labeled as "untrue" the W-B assertion that the Justice Department is "terrorizing" doctors opposing the Truman health plan.

Whitaker & Baxter lost no time in countering the Brown story. "Mr. David Brown's resignation," said W & B, "was accepted because the quality of his work was unsatisfactory and because he had sought to act without authority as a spokesman for American medicine on matters of policy. He was not serving in a policy-making capacity. His opinions with respect to the policies of the American Medical Association were neither sought



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nor considered. He had been warned that his work was unsatisfactory; he resigned as a consequence."

Seek to Cut Accidents By Nabbing Drunks

Putting the finger on drunken drivers, via wider use of scientific testing methods, may gradually reduce the number of auto-accident cases physicians have to deal with. Police from all over the country recently boned up on the testing techniques at a special Institute for Traffic Safety conducted by Yale University. The course also covered speed-control, driver education in high-schools, and what to do about jaywalkers.

Kick in the Pants For Santa Claus

Lavish Federal handouts for hospital construction kill local initiative because they encourage communities to do nothing until Santa comes around to pass out the cash. This is the opinion of the Tupelo (Miss.) Daily Journal, which puts its objections to the recent extension of the Hill-Burton Act this way:

"When he starts banging on the door with a gift every time we try to settle down to work, even Santa can become a nuisance. Thus it is with the proposal that Uncle Sam pay two-thirds, rather than one-third, of the cost of building local hospitals.

"Under Mississippi's present ho-

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...quate amounts,

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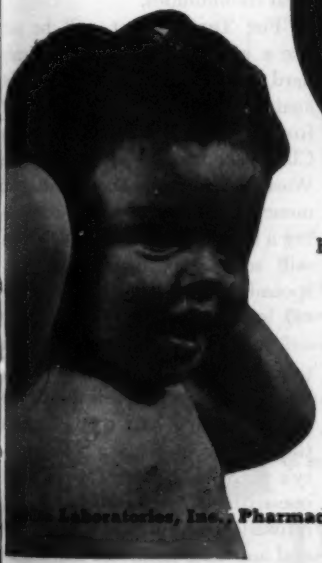

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pital construction program, each community puts up one-third of the cost of the building; the state adds another third, and the Federal Government puts up the final third. That is a reasonably sound method of local, state, and Federal cooperation.

"Under it, Mississippi has led America in developing a program to provide a modern hospital for almost every community that wants one.

"Though this three-way fund-matching plan was working with complete success even in Mississippi, poorest of all the states, Uncle Sam [will now] pay two-thirds of the cost of hospital construction, leaving only one-third to be financed jointly by states and local communities.

"For Tupelo, that will be just like a gift of $300,000. It's mighty hard to raise a voice of protest against such a generous handout from Uncle Sam. But if Santa Claus keeps dashing down from Washington with another bag of money every time we start showing a little community initiative, we will soon stop assuming any responsibility whatsoever on the local level.

"As long as a community has to put up half or at least a third of the cost of a project, it will think twice in determining how costly to make the venture. But when a community's share in a project dwindles to one-sixth or less of the total cost refusal to accept the biggest Federal and state handouts that can be

A simplified gallbladder drug regimen...

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(A Brand of Dehydrocholic Acid Comp.; Phenobarbital and Homatropine Methylbromide, P.-M. Co.)

Each tablet provides:

HYDROCHOLERESIS

...for biliary tract flushing

SPHINCTER RELAXATION

...for freer bile egress

Each tablet contains:

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Dehydrocholic Acid	250 mg. (3 3/4 grs.)
Phenobarbital	8.0 mg.
Homatropine Methylbromide	1.2 mg.

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DIVISION OF ALLIED LABORATORIES INC., INDIANAPOLIS 6, INDIANA

obtained is like kicking old Sam in the pants.

"If Congress approves the new $150 million hospital construction bill, we in Tupelo will no doubt eagerly ask our share. That is only natural, for we would be needlessly cutting our own throats to do otherwise. But there are a couple of things we can't understand about Congress' way of thinking:

"If poor old Mississippi can make outstanding progress in hospital construction under the old program of dividing costs into three equal shares, why can't the forty-seven wealthier states do the same? And if local communities don't have the money to build twice as large hospitals as they are now planning, where does Uncle Sam get the idea that he has the money to do the job for them? He's already scheduled to spend $14 billion more than he takes in during the next two years."

High Cost of Telephones Irks British Doctors

Latest plaint of British M.D.'s is that participation in the National Health Service has upped their telephone bills. They assert the Government should pick up the tab; but it refuses to do so. "I find that my telephone rental exceeds my income from the National Health Service," moans a South Harrow physician in a letter to the British Medical Journal. He would like to have his phone removed, but doesn't know whether he can legally do so under NHS regulations.

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How Effective is Undecylenic Acid in Psoriasis?

Here Are Clinical Results To Date

• Clinical reports on the treatment of 174 cases of psoriasis with undecylenic acid have been made within the last year[1,2,3,4]. These results and others as yet unpublished show the value of this new oral therapy. One hundred thirteen (65%) of the 174 cases, recalcitrant to other forms of therapy and averaging over 12 years in duration, have shown favorable response as summarized below[1,2,3,4].

68 or 39% showed 75 to 100% improvement	*Favorable*
45 or 26% showed 50 to 74% improvement	*65%*
24 or 14% showed 25 to 49% improvement	
37 or 21% showed little or no improvement	

Length of treatment varied from two to twenty-seven weeks. Improvement was first noted in a majority of the cases within three weeks after the initial use.[2] Greatest degree of improvement occurred most often between the ninth and twelfth weeks of treatment

The small guttate and circinate lesions of chronic generalized psoriasis tended to disappear much sooner than the indurated plaques of chronic localized patients.[2]

Itching completely stopped or was substantially relieved in almost all cases, regardless of degree of response of psoriatic lesions.[1,2]

In 17 cases of psoriasis associated with arthropathy it is reported that in 16, arthritic pains diminished or disappeared following oral undecylenic acid treatment[3,4,5,6].

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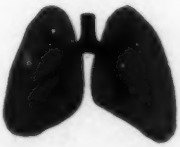

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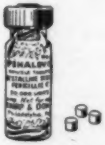
By G.I. Tract:
PENALEV tablets dissolve promptly in milk, fruit juices, or infant formulas, without appreciably changing their tastes.



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